Westchester County Department of Health
Disease Control

☐ **Check here if you need more forms**

Lyme Disease Multiple Case Report Form

Date Form Received / /

							Supplemental Information											
Patient Name	**Street Address, Town, County & State, Zip Code**	**DOB** M/D/Y	**Sex**	**Race** ■ / **Eth.** ●	**Was Pt Preg-nant?** ●	**Was Pt Hos-pital-ized?** ●	**Date of Initial Onset of Sx.** M/D/Y	**Date of DX** M/D/Y	**EM ≥ 5 cm** ●	**Recurrent Joint Effusions (swelling) Arthritis** ●	**Cranial Neuritis (Bell's Palsy)** ●	**Radiculo -Neurop or Lympho -Cytic Meningi -tis** ●	**Encephalo -Myelitis & Antibody In CSF> Seru** ●	**2° or 3° AV Bloc k** ●	**ELISA/ EIA/IF A** Δ	**Wes tern Blot** Δ	**Risk factors (tick bite, other tick disease please specify disease)**	**Physician diagnosed Lyme disease? Please list Symptoms** ●
															Total / IgM	IgG / IgM		
															Total / IgM	IgG / IgM		
															Total / IgM	IgG / IgM		
															Total / IgM	IgG / IgM		
															Total / IgM	IgG / IgM		

Reporting Individual	Phone
Address	
Signature	

Key:

■
W=White
B=Black
AP=Asian Pacific Islander
AN=American Indian/Alaskan Native
O=Other
U=Unknown

●
Y=Yes
N=No
U=Unknown
ND=Not Done

Δ
P=Positive
N=Negative
E=Equivocal
U=Unknown

Note: All blanks will be interpreted as unknown. Forms should be faxed to 914-813-5182 when completed