Putnam County Department of Health

Anaplasmosis/Ehrlichia chaffeensis/Babesiosis

Reporting Form

Patient Information	
Name:	Sex: □ Male □ Female
Address:	Pregnant: □Yes □No □ N/A
City: State: NY Zip:	Ethnicity: Hispanic? □Yes □No
Telephone:	Race:
Date of Birth:	Occupation:

Physician:	Phone #

Was patient hospitalized: □Yes □No *If yes, then*	
Hospital Name:	Medical Record #:
City: State:	Date of Admission:

Clinical Information

Date of First Symptom: _____/_____/_____ **Date of Exam:** _____/____/_____

*** Note: Critical Question, please answer:**

*** Fever** ☐Yes ☐ No *** If yes, highest temperature** _____

Malaise	□Yes □No	**Arthraglia**	□Yes □No	**Stiff Neck**	□Yes □No
Myalgia	□Yes □No	**Rash**	□Yes □No	**Chills**	□Yes □No
Headache	□Yes □No	**Rigors**	□Yes □No	**Nausea**	□Yes □No
Anemia	□Yes □No	**Leukopenia**	□Yes □No	**Thrombocytopenia**	□Yes □No
Hepatic Transaminase Elevation	□Yes □No	**Other:**			

Underlying Medical Conditions

Y N
☐ ☐ ImmunoSuppression

Y N
☐ ☐ Asplenia

Other Medical Conditions _____

Recent Illnesses/Surgeries_____

Travel

Outside of the Country: □Yes □No □Unk If yes, where?: _____
Date of Departure & Return: _____

Outside of the State: □Yes □No □Unk If yes, where?: _____
Date of Departure & Return: _____

Outside of the County: □Yes □No □Unk If yes, where?: _____
Date of Departure & Return: _____

Blood Transfusion & Tissue/Organ Transplant

In the 6 months before illness, did the patient receive a blood transfusion or platelets? □ Yes □ No
Date: ____/____/____ Hospital: _____

In the 6 months before illness, did the patient donate blood/blood components? □ Yes □ No
Date: ____/____/____ Donation site: _____

Did the patient ever receive a tissue or organ transplant? □ Yes □ No
Date: ____/____/____ Hospital: _____

If transfusion/transplant associated infections, was an infected donor identified? □ Yes □ No

In the 6 months before illness, did patient donate tissue/organ? □ Yes □ No
Date: ____/____/____ Hospital: _____

Laboratory Results:

Spec Coll Date	WBC x 1000	RBC	HGB	% HCT	Platelets x 1000	AST (SGOT)	ALT (SGPT)
__/___/___							
__/___/___							

Did patient receive treatment? ☐Yes ☐No

Date Treatment Initiated: _____/_____/_____

Duration Prescribed: □ 1 Day □7 Days □ 10 Days □ 14 Days □21 Days □28 Days □Other

Medication:

□ Atovaquone □Azithromycin □Clindamycin □Quinine □ Doxycycline

□ Other _____

Form completed by: _____ Date: _____

Please return completed form by fax to: 845-447-9490