LYME DISEASE REPORTING FORM
EMAILS WILL NOT BE ACCEPTED FAX: 613-345-5777

Please complete the following information for individuals who have or may have Lyme disease.	*FOR HEALTH UNIT USE ONLY*	
	IPHIS CASE ID:	**IPHIS CLIENT ID:**

REPORTING SOURCE		
Name:	Report Date (y/m/d):	Time:
Agency:	Phone #:	Fax #:

CLIENT INFORMATION		
Last Name:	First Name:	Gender:
DOB (y/m/d):	Phone #:	Cell #:
Address:	City:	Postal Code:
Name of Parent/Guardian (if minor):		
Occupation:		
HEALTH CARE PROVIDER:	Phone #:	Fax #:

RISK FACTORS (Check all that apply)

History of tick bite: YES ☐ NO ☐ Date (y/m/d):

If YES, where was the client most likely exposed (specify exact geographical location):

Was the client given prophylactic medication after tick bite: YES ☐ NO ☐ Date (y/m/d):

If NO history of tick bite, has client had possible exposure to ticks in the last 30 days during outdoor activities in wooded areas, either through work or recreation: YES ☐ NO ☐ Date (y/m/d):

If YES, specify exact geographical location:

CASE DETAILS

Onset Date of symptoms (y/m/d):	Date of Diagnosis (y/m/d):

Diagnosis of early localized disease (less than 30 days from exposure): YES ☐ NO ☐ Check all that apply:

☐ Erythema migrans (EM) ≥ to 5 cm in diameter ☐ Headache ☐ Fever ☐ Malaise
☐ Myalgia ☐ Neck Stiffness ☐ Fatigue ☐ Arthralgia

Diagnosis of early disseminated disease (weeks to months after exposure): YES ☐ NO ☐ Check all that apply:

☐ Multiple EM ☐ Cranial Nerve Palsies ☐ Lymphocytic Meningitis ☐ Conjunctivitis ☐ Arthralgia
☐ Myalgia ☐ Headache ☐ Fatigue ☐ Carditis (heart block)

Diagnosis of late disease (weeks to years after exposure): YES ☐ NO ☐ Check all that apply:

☐ Arrhythmias ☐ Myopericarditis ☐ Carditis (heart block) ☐ Peripheral Neuropathy ☐ Meningitis
☐ Fatigue ☐ Encephalopathy (i.e. Behaviour changes, sleep disturbance, headaches)
☐ Recurrent arthritis affecting large joints (i.e. Knees)

LABORATORY TESTING

Testing is not necessary in the early localized disease phase. Diagnostic serological testing is indicated in people who have symptoms of early or late disseminated disease (ELISA followed by Western Blot)

Was serological testing done: YES ☐ NO ☐	Date (y/m/d):
Treatment – Has the client been treated for Lyme Disease: YES ☐ NO ☐	Date (y/m/d):

Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c. H.7.

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NOTES (Response/Assessment/Intervention/Plan)			**INVESTIGATOR:**	
			iPHIS Client #:	
DATE	**TIME**		**iPHIS Case/Incident #:**	
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
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