DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

EPIDEMIOLOGY

Tick-borne Disease Case Investigation Form

DEMOGRAPHIC & CONTACT INFORMATION

First Name:	Last Name:
Date of Birth (mm/dd/yyyy): | Age:	| Sex: ☐ Female ☐ Male
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Unknown
Street Address:	
City:	State: | Zip:
County:	Home Phone #:
Cell Phone #:	Work Phone #:

PROVIDER INFORMATION

Health care provider name:
Health care provider phone number:

SYMPTOM INFORMATION

Symptom Onset date (MM/DD/YYYY):				Diagnosis date (mm/dd/yyyy):			
Fever: Highest Temperature:	☐ Yes	☐ No	☐ UNK	Malaise/fatigue:	☐ Yes	☐ No	☐ UNK
				Nausea:	☐ Yes	☐ No	☐ UNK
Rash:	☐ Yes	☐ No	☐ UNK	Vomiting:	☐ Yes	☐ No	☐ UNK
Eschar:	☐ Yes	☐ No	☐ UNK	Anorexia:	☐ Yes	☐ No	☐ UNK
Headache:	☐ Yes	☐ No	☐ UNK	Abdominal pain:	☐ Yes	☐ No	☐ UNK
Muscle aches:	☐ Yes	☐ No	☐ UNK	Leukopenia:	☐ Yes	☐ No	☐ UNK
Arthralgia:	☐ Yes	☐ No	☐ UNK	Thrombocytopenia:	☐ Yes	☐ No	☐ UNK
Elevated liver enzymes:	☐ Yes	☐ No	☐ UNK	Other symptoms:	☐ Yes	☐ No	☐ UNK

Describe other symptoms:_____

HOSPITALIZATION INFORMATION

Is the patient hospitalized? ☐ Yes ☐No ☐UNK	Hospital name:
Admission Date:	Discharge Date:

COMPLICATIONS AND OUTCOMES

Meningitis: ☐ Yes ☐ No ☐ UNK	Disseminated intravascular coagulopathy: ☐ Yes ☐ No ☐ UNK
Encephalitis: ☐ Yes ☐ No ☐ UNK	Adult respiratory distress syndrome: ☐ Yes ☐ No ☐ UNK
Renal failure: ☐ Yes ☐ No ☐ UNK	Other:_____
Describe other complications:	
New Medications prescribed:	

Patient Died: ☐ Yes ☐ No ☐UNK	Recovered without complications: ☐Yes ☐No ☐UNK

EXPOSURE INFORMATION

Tick bite

In the 15 days prior to symptom onset, did the case have a tick bite?
☐Yes ☐No ☐UNK

Travel History

In the 15 days prior to symptom onset did the case travel outside Delaware?
☐Yes ☐No ☐UNK

If yes, location of travel:_____

Blood Donation within 30 days prior to onset? yes/no

If yes, provide date of donation

Receive blood transfusion in the year prior to onset? Yes/no

If yes, provide date of transfusion

Receive an organ transplant a year prior to symptom onset? Yes/ no

If yes, provide date of transplant and which organs

Thank you for completing this form. Please return to the Office of Infectious Disease Epidemiology via secure fax 302-622-4149 or email reportdisease@delaware.gov