

**NJDOH EHRLICHIOSIS / ANAPLASMOSIS INVESTIGATION WORKSHEET**

MR #: \_\_\_\_\_

CDRSS #: \_\_\_\_\_

**DEMOGRAPHICS**

Patient Last Name		First Name		DOB: ____ / ____ / ____	Phone number
Address				City	Municipality
<b>Race</b> White                      Black                      American Indian or Alaskan Native Asian                        Pacific Islander        Unknown				<b>Ethnicity</b> Hispanic Non-Hispanic                      Unknown	
<b>Indicate Disease Investigated</b> Anaplasmosis - <i>Anaplasma phagocytophilum</i> Ehrlichiosis - <i>Ehrlichia chaffeensis</i> Ehrlichiosis/Anaplasmosis - Undetermined                      Ehrlichiosis - <i>Ehrlichia ewingii</i>				<b>Pregnancy status</b> Pregnant Not pregnant N/A    Unknown	

**CLINICAL INFORMATION**

Date first seen by a medical professional ____ / ____ / ____	Onset Date ____ / ____ / ____	Diagnosis:
<b>Signs/Symptoms</b>	<b>Response</b>	<b>Onset Date</b>
Anemia	Yes      No      Unk.	____ / ____ / ____
Chills	Yes      No      Unk.	____ / ____ / ____
Elevated liver enzymes	Yes      No      Unk.	____ / ____ / ____
Fever, Tmax _____ F	Yes      No      Unk.	____ / ____ / ____
Headache	Yes      No      Unk.	____ / ____ / ____
Jaundice	Yes      No      Unk.	____ / ____ / ____
Leukopenia	Yes      No      Unk.	____ / ____ / ____
Myalgia	Yes      No      Unk.	____ / ____ / ____
Rash	Yes      No      Unk.	____ / ____ / ____
Thrombocytopenia	Yes      No      Unk.	____ / ____ / ____
Vomiting	Yes      No      Unk.	____ / ____ / ____
Other <i>specify</i> :		____ / ____ / ____

<b>Was an underlying immunosuppressive condition present?</b> Yes, <i>specify</i> _____ No Unknown	<b>Specify any life-threatening complications in the clinical course of illness:</b> Adult respiratory distress syndrome (ARDS) Meningitis/encephalitis Disseminated intravascular coagulopathy Renal failure Other: _____ None
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<b>Was patient hospitalized because of this illness?</b> Yes, <i>specify location and date(s)</i> Hospital name: _____ Admission: ____ / ____ / ____      Discharge: ____ / ____ / ____ Diagnosis: _____ No	<b>Did the patient die because of this illness?</b> Yes, <i>specify date</i> ____ / ____ / ____ No Unknown
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**TREATMENT INFORMATION**

Treatment	Dosage	Dates
Doxycycline		___ / ___ / ___ to ___ / ___ / ___
Rifampin		___ / ___ / ___ to ___ / ___ / ___
Other: _____		___ / ___ / ___ to ___ / ___ / ___
Not treated		

**RISK FACTORS**

Risk factor	Response		
In the 14 days prior to illness onset/diagnosis, did the patient spend time outdoors in grassy or wooded areas?	Yes	No	Unk.
In the 14 days prior to illness onset/diagnosis, did the patient notice a tick bite? <i>If yes, specify location of tick bite.:</i>	Yes	No	Unk.
In the 30 days prior to illness onset/diagnosis, did the patient receive a blood transfusion? <i>If yes, provide a list of transfusion date(s), hospital where transfused, type of blood product(s), and source of blood products:</i>	Yes	No	Unk.
In the 30 days prior to illness onset/diagnosis, did the patient receive an organ transplant? <i>If yes, list type of organ, date, hospital:</i>	Yes	No	Unk.

**ADDITIONAL CASE NOTES**