NJDOH BABESIOSIS INVESTIGATION WORKSHEET

CDRSS #: _____

Patient Last Name	**First Name**	**Middle Initial**	**DOB:** ____ / ____ / ____	**Ethnicity** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race
☐White ☐ Black ☐Asian ☐Pacific Islander ☐American Indian or Alaskan Native ☐Unknown

Occupation	**Industry / work setting**

Was patient hospitalized because of this illness? ☐ Yes ☐ No ☐ Unknown Hospital: _____ Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____	**Did the patient die because of this illness?** ☐ Yes ☐ No ☐ Unknown If yes, specify date of death: ____ / ____ / ____

Signs & Symptoms		**Onset Date**
*Anemia Hgb _____	☐ Yes ☐ No ☐ Unk.	____ / ____ / ____
Arthralgia (joint pain)	☐ Yes ☐ No ☐ Unk	____ / ____ / ____
Chills	☐ Yes ☐ No ☐ Unk	____ / ____ / ____
Fever Temp _____ F	☐ Yes ☐ No ☐ Unk	____ / ____ / ____
Headache	☐ Yes ☐ No ☐ Unk	____ / ____ / ____
Myalgia (muscle aches)	☐ Yes ☐ No ☐ Unk	____ / ____ / ____
Sweats	☐ Yes ☐ No ☐ Unk	____ / ____ / ____
*Thrombocytopenia Platelet ct: _____	☐ Yes ☐ No ☐ Unk	____ / ____ / ____
Other:		____ / ____ / ____

Risk Factors	
In the 12 months prior to illness onset or diagnosis, did the patient receive a blood transfusion? If yes, provide a list of transfusion date(s), hospital where transfused, type of blood product(s), and source of blood products.	☐ Yes ☐ No ☐ Unk
In the 30 days prior to illness onset or diagnosis, did the patient receive an organ transplant? If yes, list type of organ, date, hospital: _____	☐ Yes ☐ No ☐ Unk
In the 8 weeks before illness onset or diagnosis, did the patient spend time outdoors in grassy or wooded areas?	☐ Yes ☐ No ☐ Unk
In the 8 weeks prior to illness onset or diagnosis, did the patient notice a tick bite?	☐ Yes ☐ No ☐ Unk
Is the patient asplenic? If yes, date of splenectomy: ___ / ___ / _____	☐ Yes ☐ No ☐ Unk
In the 12 months prior to illness onset or diagnosis, did the patient donate blood? If yes, date(s) and locations(s): _____	☐ Yes ☐ No ☐ Unk
Was an immunosuppressive condition present? Is yes, specify: _____	☐ Yes ☐ No ☐ Unk
Other:	☐ Yes ☐ No ☐ Unk

Treatment (Check all that apply)	
☐ Azithromycin	Start date:__ /___/___ End date: ___/___/___
☐ Atovaquone	Start date:__ /___/___ End date: ___/___/___
☐ Clindamycin	Start date:__ /___/___ End date: ___/___/___
☐ Quinine	Start date:__ /___/___ End date: ___/___/___
☐ Other antibiotic: _____	Start date:__ /___/___ End date: ___/___/___
☐ Exchange transfusion	Date(s):

Were there any complications of babesiosis?
☐None ☐Adult Respiratory Distress Syndrome ☐Congestive Heart Failure ☐Myocardial Infarction ☐Meningitis / encephalitis
☐Renal failure ☐Disseminated intravascular coagulopathy ☐Other _____

Comments:

***Below the reference range of the lab where the sample was analyzed**

Revised 07/25/2018