NJDOH ANAPLASMOSIS INVESTIGATION WORKSHEET **MR #:** ___________ **CDRSS #:** ___________

DEMOGRAPHICS

Patient Last Name	First Name	DOB: ____ / ____ / ____	Phone number
Address		**City**	**Municipality**

Race

White Black American Indian or Alaskan Native
Asian Pacific Islander Unknown

Ethnicity

Hispanic
Non-Hispanic Unknown

Sex	**Industry (work setting)**	**Occupation (job title)**

CLINICAL INFORMATION

Date first seen by a medical professional	Onset Date	Diagnosis:
_____ / _____ / _____	_____ / _____ / _____	

Signs/Symptoms	Response			Onset Date
Acute respiratory distress syndrome (ARDS)	Yes	No	Unk.	_____ / _____ / _____
Anemia	Yes	No	Unk.	_____ / _____ / _____
Asymptomatic	Yes	No	Unk.	_____ / _____ / _____
Chills	Yes	No	Unk.	_____ / _____ / _____
Disseminated Intravascular coagulation (DIC)	Yes	No	Unk.	_____ / _____ / _____
Elevated c-reactive protein	Yes	No	Unk.	_____ / _____ / _____
Elevated liver enzymes	Yes	No	Unk.	_____ / _____ / _____
Encephalitis	Yes	No	Unk.	_____ / _____ / _____
Fatigue	Yes	No	Unk.	_____ / _____ / _____
Fever, Tmax ________F	Yes	No	Unk.	_____ / _____ / _____
Headache	Yes	No	Unk.	_____ / _____ / _____
Leukopenia	Yes	No	Unk.	_____ / _____ / _____
Malaise	Yes	No	Unk.	_____ / _____ / _____
Meningitis	Yes	No	Unk.	_____ / _____ / _____
Myalgia	Yes	No	Unk.	_____ / _____ / _____
Organ failure *specify:*	Yes	No	Unk.	_____ / _____ / _____
Sweats	Yes	No	Unk.	_____ / _____ / _____
Thrombocytopenia	Yes	No	Unk.	_____ / _____ / _____
Other *specify*:				_____ / _____ / _____

Did the patient experience any severe complications of the following in the clinical course of illness: acute respiratory distress syndrome, disseminated intravascular coagulation, meningitis, encephalitis, or organ failure?

Yes, *specify*____________________ No Unknown

In the 30 days prior to illness onset or diagnosis, did the patient donate blood?

Yes, *Date of blood donation:* ____________________ No Unknown

Location of blood donation: ____

Was an underlying immunosuppressive condition present?

Yes, *specify*____________________ No Unknown

Was patient hospitalized because of this illness?	**Did the patient die because of this illness?**
Yes, *specify location and date(s)* Hospital name: ____ Admission: ____ / ____ / ____ Discharge: ____ / ____ / ____ Diagnosis:____ No	Yes, *specify date* ____ / ____ / ____ No Unknown

TREATMENT INFORMATION

Treatment	Dosage	Dates
Doxycycline		____ / ____ / ____ to ____ / ____ / ____
Other: ____________________		____ / ____ / ____ to ____ / ____ / ____
Other: ____________________		____ / ____ / ____ to ____ / ____ / ____
Not treated		

RISK FACTORS

Risk factor	Response
In the year days prior to illness onset/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 year prior to illness onset/diagnosis, did the patient receive an organ transplant? *If yes, list type of organ, date, hospital:*	Yes No Unk.
In the 14 days prior to illness onset/diagnosis, did the patient notice a tick bite? *If yes, specify location of tick bite:* *Date of tick bite:* ____ / ____ / ____	Yes No Unk.
In the 14 days prior to illness onset/diagnosis, did the patient spend time outdoors in grassy or wooded areas?	Yes No Unk.

ADDITIONAL CASE NOTES