

NJDOH BABESIOSIS INVESTIGATION WORKSHEET

CDRSS #: _____

Patient Last Name	First Name	Middle Initial	DOB: ____/____/____	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Unknown				
Occupation			Industry / work setting	
Was patient hospitalized because of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hospital: _____ Admitted: ____/____/____ Discharged: ____/____/____			Did the patient die because of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify date of death: ____/____/____	
Signs & Symptoms				Onset Date
Fever: _____ F			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	____/____/____
*Anemia: Hgb _____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	____/____/____
*Thrombocytopenia: Plt ct _____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	____/____/____
Chills			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	____/____/____
Sweats			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	____/____/____
Headache			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	____/____/____
Myalgia			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	____/____/____
Arthralgia / joint pain			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	____/____/____
Other:				____/____/____
Other:				____/____/____
Risk Factors				
In the 8 weeks before illness onset or diagnosis, did the patient spend time outdoors in grassy or wooded areas?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
In the 8 weeks prior to illness onset or diagnosis, did the patient notice a tick bite?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
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.			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
In the 12 months prior to illness onset or diagnosis, did the patient donate blood? If yes, date(s) and location(s): _____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Is the patient asplenic? If yes, date of splenectomy: ____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Was an immunosuppressive condition present? Is yes, specify: _____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Treatment (Check all that apply)				
<input type="checkbox"/> Azithromycin		Start date: ____/____/____	End date: ____/____/____	
<input type="checkbox"/> Atovaquone		Start date: ____/____/____	End date: ____/____/____	
<input type="checkbox"/> Clindamycin		Start date: ____/____/____	End date: ____/____/____	
<input type="checkbox"/> Quinine		Start date: ____/____/____	End date: ____/____/____	
<input type="checkbox"/> Other antibiotic: _____		Start date: ____/____/____	End date: ____/____/____	
<input type="checkbox"/> Exchange transfusion		Date(s): _____		
Were there any complications of babesiosis?				
<input type="checkbox"/> None <input type="checkbox"/> Adult Respiratory Distress Syndrome <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Meningitis / encephalitis				
<input type="checkbox"/> Renal failure <input type="checkbox"/> Disseminated intravascular coagulopathy <input type="checkbox"/> Other _____				
Comments:				

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