

SECTION 2 – CLINICAL PRESENTATION (cont'd)

Presentation	Yes	No	Duration of the symptoms prior to diagnosis (days)	Symptoms important in diagnosis
Polyarthritis				
Arthralgia				
Bell's palsy (facial paralysis)				
Other cranial neuropathy				
Radiculoneuropathy				
Meningitis/Lymphocytic meningitis				
Encephalitis/Encephalomyelitis				
Lyme carditis				
A-V heart block				
Palpitations/Arrhythmia				
Headache				
Fever				
Other relevant signs? (Please describe)				

SECTION 3 – LABORATORY DATA

3.1 Was the diagnosis made based only on clinical presentation (e.g., EM) without laboratory testing?

Yes___ No___ Unknown___ **If yes, skip to Section 4**

3.2 Laboratory testing (check and complete all that apply)

3.2.1 Serological testing (enter all tests completed, including repeat tests – see options below table)

Serological Test	Date DD / MM / YYYY	Positive/ reactive	Negative/ non-reactive	Borderline/ weakly reactive	Unreadable	Not completed
Other:						

Test options: ELISA, IFA, C6, Western Blot IgM, Western Blot IgG, CSF serology

3.2.2 Name(s) of the laboratory(ies) that completed sample testing: _____

3.2.3 PCR

Sample one: Tissue biopsy___ Synovial fluid___ CSF___ Other, specify: _____

Result: Positive___ Negative___ Indeterminate___

Sample two: Tissue biopsy___ Synovial fluid___ CSF___ Other, specify: _____

Result: Positive___ Negative___ Indeterminate___

Where was PCR completed? _____

3.2.4 Culture

Sample one: Tissue biopsy___ Synovial fluid___ CSF___ Other, specify: _____

Result: Positive___ Negative___ Indeterminate___

Sample two: Tissue biopsy___ Synovial fluid___ CSF___ Other, specify: _____

Result: Positive___ Negative___ Indeterminate___

SECTION 3 – LABORATORY DATA (cont'd)

3.3 Was any diagnostic testing conducted outside of Canada? Yes___ No___ Unknown___
If yes, indicate: Laboratory used _____
 Tests _____
 Results _____

3.4 Case meets the following Lyme disease surveillance definition criteria:
 Confirmed___ Probable 1___ Probable 2___

SECTION 4 – TREATMENT

Yes No Unknown

4.1 Did the patient have a history of a tick bite? ___ ___ ___

4.2 Did the patient receive care in an Emergency room? ___ ___ ___

If yes, the visit was for: a tick bite ___ or Lyme disease symptoms ___

4.3 If the patient had a history of a tick bite, did he/she receive a prophylactic treatment? ___ ___ ___

If yes, specify antibiotic: _____

Treatment is: Complete___ Ongoing___ Duration of treatment _____

4.4 Was patient hospitalized for treatment? ___ ___ ___

If yes, duration of hospitalization _____

4.5 List of medications used in empiric or definitive treatment (does not include prophylaxis):

Medication	Yes	No	Dose (per kg body weight)	Frequency (per day)	Duration (days) (actual or planned)
Amoxicillin					
Doxycycline					
Ceftriaxone					
Anti-inflammatory medication – Other:					

SECTION 5 – TREATMENT OUTCOME (completion of this section may require follow-up. If treatment outcome is not yet known, please leave all entries blank.)

5.1 Did the patient have persistent or recurrent symptoms after a recommended course of oral or IV antibiotics? **Yes No Unknown**
 ___ ___ ___

If yes, specify antibiotic: _____

If no, specify symptoms: _____

5.2 Did the patient show improvement with a subsequent course of antibiotics? ___ ___ ___

If yes, specify antibiotic and route: _____

If no, specify symptoms: _____ Duration: _____

SECTION 6 – ENVIRONMENTAL EXPOSURE HISTORY

6.1 Did the patient reside in or visit a Lyme disease endemic or risk* **area in Canada** within 30 days of the onset of the symptoms? Yes___ No___ Unknown___

* *Known endemic and risk areas in Canada include parts of southern Ontario, Quebec, Nova Scotia, New Brunswick, Manitoba and southern British Columbia (please see provided map)*

If yes: date: ___ / ___
 MM YYYY

Province _____ / County _____ / Town or City _____ / Park _____

6.2 Did the patient reside in or visit a Lyme disease endemic area **outside of Canada** within 30 days of the onset of the symptoms? Yes___ No___ Unknown___

If yes: date: ___ / ___
 MM YYYY

USA___ Europe___ Asia___

State _____ / Town or City _____ / Park _____

SECTION 6 – ENVIRONMENTAL EXPOSURE HISTORY (cont'd)

6.3 Did the patient have a history of a tick bite within 30 days of the onset of the symptoms?

Yes___ No___ Unknown___ **If no or unknown, go to question 6.4**

If yes: Province_____ / County_____ / Town or City_____ / Park_____

6.4 In what type of environment was the patient when bitten by the tick(s)? (Check all that apply)

Forest___ National or provincial park___ Private or public garden___ Municipal park___

Farmland/Meadow___ Unknown___ Other, specify: _____

6.5 Describe the activities that the patient was engaged in when they were exposed to the tick(s)? (Check all that apply)

Playing___ Dog walking___ Picnic___ Hiking___ Gardening___ Camping___ Sports___

Hunting/fishing___ Unknown___ Other, specify: _____

___ **I agree to be contacted by the CPSP for further information on this questionnaire, especially about section 5, if not completed at the time of submission.**

___ **I do not wish to be contacted by the CPSP for further information.**

SECTION 7 – REPORTING PHYSICIAN

First name_____ Surname_____

Address_____

City_____ Province_____ Postal code_____

Telephone number_____ Fax number_____

E-mail_____ Date completed_____

Thank you for completing this questionnaire.