Babesiosis Field Form

Patient Demographics						
Name of Patient:						
Date of Birth:						
Sex:	Male	☐	Female	☐	Unknown	☐
Deceased:	Yes	☐	No	☐	Unknown	☐
Deceased Date:						
Parent/Guardian Name:						
Home Phone:						
Work Phone:						
Cell Phone:						
Address Line 1:						
Address Line 2:						
City/State/Zip						
County (Required):						
Country:						

General Illness						
Date Patient Sought Initial Medical Evaluation:						
Location First Seen:						
Physician Name:						
Physician Address:						
Physician City/State/Zip:						
Disease Onset Date:						
Diagnosis Date: (if applicable)						
Was Patient seen in ER?	Yes	☐	No	☐	Unknown	☐
ER Hospital Name & Address:						
Admitted to Hospital?	Yes	☐	No	☐	Unknown	☐

Same as ER hospital?	Yes ☐	No ☐	Unknown ☐
If not the same, name of new hospital:			
Admission date:			
Discharge date:			
Is the patient pregnant? (Required of females with the age of onset between 8 & 60)	Yes ☐	No ☐	Unknown ☐
Estimated due date:			
Calculated based on:			
If patient died, was death due to the disease/condition under investigation?	Yes ☐	No ☐	Unknown ☐

Clinical Symptoms	**Please Check ALL that Apply**		
Fever (>100.4 F or >38C):	Yes ☐	No ☐	Unknown ☐
Highest Fever:			
Chills:	Yes ☐	No ☐	Unknown ☐
Sweats:	Yes ☐	No ☐	Unknown ☐
Headache:	Yes ☐	No ☐	Unknown ☐
Myalgia:	Yes ☐	No ☐	Unknown ☐
Arthralgia:	Yes ☐	No ☐	Unknown ☐
Malaise:	Yes ☐	No ☐	Unknown ☐
Fatigue:	Yes ☐	No ☐	Unknown ☐
Generalized Weakness:	Yes ☐	No ☐	Unknown ☐
Other Symptoms: (Please List)			

Physician Diagnosis **(In Absence of Alternative Explanation)**	**Please Check ALL that Apply**		
Enlarged Liver:	Yes ☐	No ☐	Unknown ☐
Enlarged Spleen:	Yes ☐	No ☐	Unknown ☐

Severe Hemolytic Anemia: (Hemolysis)	Yes ☐	No ☐	Unknown ☐
Acute Respiratory Distress Syndrome (ARDS):	Yes ☐	No ☐	Unknown ☐
Renal Failure:	Yes ☐	No ☐	Unknown ☐

Lab Findings	**Please Check ALL that Apply**		
Thrombocytopenia: (Platelet Count <100,000/mm3)	Yes ☐	No ☐	Unknown ☐
Lowest platelet count:			
Anemia: (Hemoglobin <12.0g/dL)	Yes ☐	No ☐	Unknown ☐
Elevated Liver Enzymes: (AST>35 U/L; ALT>35 U/L)	Yes ☐	No ☐	Unknown ☐
Protein in Urine:	Yes ☐	No ☐	Unknown ☐
Blood in Urine:	Yes ☐	No ☐	Unknown ☐
Elevated BUN:	Yes ☐	No ☐	Unknown ☐
Elevated Creatinine:	Yes ☐	No ☐	Unknown ☐

Predisposing Conditions	**Please Check ALL that Apply**		
Has the patient's spleen been removed?	Yes ☐	No ☐	Unknown ☐
Impaired Immune function (e.g., HIV, malignancy, corticosteroid therapy)	Yes ☐	No ☐	Unknown ☐
Has the patient taken immunosuppressive therapies?	Yes ☐	No ☐	Unknown ☐
Disseminated Intravascular Coagulation (DIC)?	Yes ☐	No ☐	Unknown ☐
Hemodynamic Instability? (<90/60)	Yes ☐	No ☐	Unknown ☐
Lowest systolic blood pressure (mmHg)			
Lowest diastolic blood pressure (mmHg)			
Myocardial Infarction?	Yes ☐	No ☐	Unknown ☐
Altered Mental Status?	Yes ☐	No ☐	Unknown ☐

Treatment	**Please Check ALL that Apply**		
Did patient receive antibiotics?	Yes ☐	No ☐	Unknown ☐
Antibiotic(s) given:			
Date Antibiotic Started:			
Total Days Antibiotic Taken:			
Were antibiotics taken as prescribed?	Yes ☐	No ☐	Unknown ☐

Additional Comments