Rhode Island Department of Health

CONFIDENTIAL CASE REPORT
RHODE ISLAND DEPARTMENT OF HEALTH
3 CAPITOL HILL, PROVIDENCE RI 02908 Fax: 401-222-2488

Use this form to report
Babesiosis

☐ Confirmed ☐ Probable ☐ Suspect
Epi-link to: _____

Last Name _____ **First Name** _____ **MI**_____

Address _____ **Phone (**_____**)** _____**-**_____

City _____ **State** _____ **Zip** _____

Birthdate: _____ **/**____ **/**____

Age _____

Race ☐ American Indian / Alaskan ☐ White ☐ Asian / Pacific Islander ☐ Other ☐ Black / African American ☐ Unknown

Hispanic ☐ Yes ☐ No ☐ Unknown

Gender ☐ Male ☐ Female ☐ Unknown

CLINICAL and TREATMENT INFORMATION

Date of Illness Onset: _____/_____/_____

	Y	N	U		Y	N	U		Y	N	U	
Objective Symptoms	☐	☐	☐	Anemia	☐	☐	☐	Arthralgia	☐	☐	☐	Myalgia
	☐	☐	☐	Fever (Highest Temp: ___ °F)	☐	☐	☐	Chills	☐	☐	☐	Sweats
	☐	☐	☐	Thrombocytopenia	☐	☐	☐	Headache				

Additional Signs and Symptoms (check all that apply)

- ☐ Dark Urine
- ☐ Fatigue
- ☐ Hemolytic Anemia
- ☐ Hepatomegaly
- ☐ History of Splenectomy
- ☐ Jaundice
- ☐ Malaise
- ☐ Splenomegaly
- ☐ Weakness
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Complications on Infection (check all that apply)

- ☐ Acute Respiratory Distress
- ☐ Altered Mental Status
- ☐ Disseminated Intravascular Coagulation
- ☐ Hepatic Compromise
- ☐ Myocardial Infarction
- ☐ Renal Distress
- ☐ Other: _____/_____/_____

Clinical Information

Y	N	U		
☐	☐	☐	Is/was the patient pregnant during illness?	Weeks Pregnant: _____ Due Date: ____/_____/_____
☐	☐	☐	Underlying immunosuppressive condition exist?	Conditions: / /
☐	☐	☐	Prescribed Treatment	☐ Azithromycin ☐ Atovaquone ☐ Chloroquine ☐ Clindamycin ☐ Quinine ☐ Quinidine
☐	☐	☐	Did patient die due to illness?	Date of Death: _____/_____/_____ ☐ Other: _____

Provider and Hospitalization Information

Physician: _____ Phone (____) _____-_____ Hospitalized: ☐ Y ☐ N

Hospital: _____ Admission Dt: ____/_____/____ Discharge Dt: ____/_____/____

Reporting Information

Date of Report: ____/____/_____ Reporting Provider: _____ Reporting Organization:_____

TRAVEL and EXPOSURE HISTORY

Y	N	U	
☐	☐	☐	History of tick bite(s) in the 8 Weeks Prior to Illness Onset Date?
			Approximate Date of Bite: ___/____/____ Location of Bite: City: _____ State: _____
☐	☐	☐	Has Patient Traveled in the 8 Weeks Prior to Illness Onset Date?

Location: _____ Date: __/___/___ Location: _____ Date: __/___/___ Location: _____ Date: __/___/___

BLOOD TRANSFUSION INFORMATION (up to 12 months prior to onset)

Y	N	U				
☐	☐	☐	Did the Patient Donate Blood?	Date: ___/___/____	Date: ___/___/____	Date: ___/___/____
☐	☐	☐	Did the Patient Receive Blood?	Date: ___/___/____	Date: ___/___/____	Date: ___/___/____
☐	☐	☐	Did the Patient Donate an Organ?	Date: ___/___/____	Date: ___/___/____	Date: ___/___/____
☐	☐	☐	Did the Patient Receive an Organ?	Date: ___/___/____	Date: ___/___/____	Date: ___/___/____

Babesiosis Case Report Form - This page for Department of Health Use Only

Last Name _____ **First Name** _____

BLOOD TRANSFUSION INFORMATION (up to 12 months prior to onset)

Y	N	U		Date	Bag/Unit #:	Blood Product Type
☐	☐	☐	Did the Patient Receive Blood?			
			1	____/_____/____	_____	_____
			2	____/_____/____	_____	_____
			3	____/_____/____	_____	_____
			4	____/_____/____	_____	_____
			5	____/_____/____	_____	_____

Y	N	U		Date	Bag/Unit #:	Blood Product Type
☐	☐	☐	Did the Patient Donate Blood?			
			1	____/_____/____	_____	_____
			2	____/_____/____	_____	_____
			3	____/_____/____	_____	_____
			4	____/_____/____	_____	_____
			5	____/_____/____	_____	_____

For Blood Product Type use only the following: Whole Blood, RBC (or packed RBC), Platelet (or platelet concentrate), Plasma (or FFP), Cryoprecipitate, WBC (or granulocyte), Ig, Unknown, Other (specify)

Y	N	U				
☐	☐	☐	Did the Patient Receive an Organ?	Date: ___/___/____	Date: ___/___/____	Date: ___/___/____
☐	☐	☐	Did the Patient Donate an Organ?	Date: ___/___/____	Date: ___/___/____	Date: ___/___/____

LABORATORY DATA

Name of Laboratory: _____

Laboratory Confirmed Criteria

- ☐ Isolation of *Babesia* Organisms by light Microscopy in a Stained Blood Smear
- ☐ Detection of *Babesia microti* DNA in a whole blood specimen by PCR
- ☐ Detection of *Babesia* genomic sequences in a whole blood specimen by nucleic acid amplification
- ☐ Isolation of *Babesia* organism from whole blood specimen

Laboratory Supportive Criteria

- ☐ *Babesia microti* IFA-total Ig or IFA-IgG titer ≥ 1:256 (or ≥ 1:64 in linked blood donor or recipient) Date of Test Result: ___/____/____
- ☐ Positive Immunoblot IgG result for *Babesia microti* Date of Test Result: ___/____/____
- ☐ *Babesia divergens* IFA-total Ig or IFA-IgG titer ≥ 1:256 Date of Test Result: ___/____/____
- ☐ *Babesia duncani* IFA-total Ig or IFA-IgG titer ≥ 1:512 Date of Test Result: ___/____/____

INVESTIGATOR NOTES

CASE CLASSIFICATION

- ☐ **Confirmed** (if all of the following apply)
  - ☐ **Lab results match at least one criterion for 'Lab Confirmed'**
  - ☐ **At least one Objective or Subjective symptoms are present**
- ☐ **Probable** (must meet one of the following)
  - ☐ **At least one criterion for 'Lab Supportive' is present with at least one Objective symptom**
  - ☐ **Blood donor or recipient is epidemiologically linked to a confirmed or probable case and**
    - ☐ **a) is 'Lab Confirmed' but no Objective or Subjective symptoms are present *OR***
    - ☐ **b) is 'Lab Supportive' with or without Subjective symptoms but no Objective symptoms**
- ☐ **Suspect:** Only 'Lab Confirmed' or 'Lab Supportive' results are present (only lab report was provided)
- ☐ **Not a Case**

ADMINISTRATIVE INFORMATION

Investigator's Name: _____ Date: ___/____/____