Please complete the following and return form to:
Ottawa Public Health
Communicable Disease Program
100 Constellation Drive, 8 East
Ottawa, Ontario, K2G 6J8
Fax: 613-580-9640

Ottawa | Public Health
Santé publique

Health Care Provider Lyme Disease Reporting Form

Patient Information					
Last name:		First name:			
DOB (yyyy-mm-dd):	Age:	Gender:	Health card number:		
Address:		City:	Province:	Postal code:	
Telephone #:		Cell phone #:			

Symptoms ***(please complete every line)***	**Yes**	**Onset date (yyyy-mm-dd)**	**No**	**Unknown**
Neurological				
Auditory symptoms				
Bell's palsy/other cranial neuritis				
Cognitive impairment				
Headache				
Hearing impairment				
Lymphocytic meningitis/ encephalitis/ encephalomyelitis				
Memory loss				
Neck pain				
Paresthesias				
Radiculoneuropathy				
Visual symptoms				
Dermatological				
Cellulitis				
Erythema migrans (EM) greater than 5 cm in diameter Size of EM in cm:_____ Physician observed ☐ Yes ☐ No				
Rash				
Musculoskeletal				
Arthralgia				
Arthritis				
Myalgia				
Cardiac				
A-V heart block (second or third degree)				
Carditis				
Palpitations/arrhythmia				
Constitutional				
Fatigue				
Fever				
Lymphadenopathy				
Other:				

Was the patient tested for Lyme Disease?	☐ No ☐ Yes, please complete information below
Was the test for Lyme Disease performed in Ontario?	☐ No, specify where test was done: ☐ Yes ☐ Unknown

Was the patient prescribed treatment?	☐ No ☐ Yes, please complete information below:
Drug:	Date:
Dosage, unit, route:	Duration of treatment:
Frequency:	Prescribed by:

Was the patient bitten by a tick? ☐ No ☐ Yes, please complete information below:
When did the tick bite occur?
Where was the tick acquired? Please provide details:

Did the patient submit a tick for testing? ☐ No ☐ Yes
If yes, was the tick submitted by the physician? ☐ No ☐ Yes

Hospitalization
Did the patient visit an emergency department? ☐ No ☐ Yes Name of hospital: Date of visit:
Was the patient admitted to hospital as a result of Lyme Disease? ☐ No ☐ Yes Name of hospital: Admission date: Discharge date:

Outcome:	
☐ Recovered ☐ Residual effects ☐ Still ill ☐ Unknown ☐ Fatal, please complete information below:	
Date of death:	Cause of death:
Did Lyme Disease contribute to death but was not the underlying cause of death? ☐ No ☐ Yes **Was Lyme Disease the underlying cause of death? ☐ No ☐ Yes** **Was Lyme Disease unrelated to the cause of death? ☐ No ☐ Yes** **Was it unknown if Lyme Disease was cause of death? ☐ No ☐ Yes**	

Health Care Provider (print name): _____ Signature: _____