Form Approved
OMB No. 0920-0728

Babesiosis Case Report Form

Completed forms can be submitted to babesiosis@cdc.gov

Case ID: **Date Submitted:** Reset Form

Classify case based on the 2025 CDC case definition: ○ Confirmed ○ Probable ○ Suspect

Demographic and Clinical Data *For dates, be as specific as possible. However, approximates [e.g., mm/yyyy] are acceptable.*

State of residence: Postal abrv. **County of residence:** **Zip code:** **Sex:** ○ Male ○ Female ○ Unknown **Date of birth** *mm / dd / yyyy* **Age:** ○ years ○ months ○ days

Race (Check all that apply): ☐ White ☐ Black/African American ☐ Alaska Native or American Indian ☐ Asian ☐ Pacific Islander ☐ Not specified

Ethnicity: ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Unknown

Was the person symptomatic? ○ Yes ○ No ○ Unknown If yes, date of onset: *mm / dd / yyyy*

Is the person asplenic? ○ Yes ○ No ○ Unknown If splenectomy, date of surgery: *mm / dd / yyyy*

Was the person immunocompromised? ○ Yes ○ No ○ Unknown

If immunocompromised, what was the associated condition or treatment?

Clinical Manifestations

	Yes	No	Unknown		Yes	No	Unknown		Yes	No	Unknown		Yes	No	Unknown
Fever	○	○	○	Headache	○	○	○	Chills	○	○	○	Myalgia	○	○	○
Anemia	○	○	○	Thrombocytopenia	○	○	○	Sweats	○	○	○	Arthralgia	○	○	○

Other clinical manifestations (specify):

Specify any complications in the clinical course of infection:

☐ Acute respiratory distress ☐ Congestive heart failure ☐ Renal failure ☐ None
☐ Disseminated intravascular coagulation (DIC) ☐ Myocardial infarction ☐ Other:

Was the person hospitalized (at least overnight) for this infection? ○ Yes ○ No ○ Unknown If yes, number of days:

Did the person die? ○ Yes ○ No ○ Unknown If yes, date of death: *mm / dd / yyyy*

Was the death related to the infection? ○ Yes ○ No ○ Unknown

Did the person receive antimicrobial treatment for this infection? ○ Yes ○ No ○ Unknown

If yes, which drugs (select all that apply)? ☐ Clindamycin ☐ Quinine ☐ Atovaquone ☐ Azithromycin ☐ Other

Epidemiologic Factors

In the year before symptom onset or diagnosis (use earlier date), did the person:

Receive a blood transfusion? ○ Yes ○ No ○ Unknown

Was the person's infection tranfusion associated? ○ Yes ○ No ○ Unknown If yes, date(s) of transfusion: Date 1 *mm / dd / yyyy* Date 2 *mm / dd / yyyy*

If a transfused blood product was implicated in an investigation, specify which type(s) of product:
☐ Plasma ☐ Platelet ☐ Red blood cell ☐ Unknown ☐ Other:

In the month before symptom onset or diagnosis (use earlier date), did the person:

Receive an organ transplant? ○ Yes ○ No ○ Unknown

Was the person an infant born to a mother who had babesiosis or *Babesia* infection during pregnancy? ○ Yes ○ No ○ Unknown

In the eight weeks before symptom onset or diagnosis (use earlier date), did the person:

Engage in outdoor activities? ○ Yes ○ No ○ Unknown If yes, which: ☐ Camping ☐ Hiking ☐ Hunting ☐ Yard work ☐ Other:

Spend time outdoors in or near wooded or brushy areas? ○ Yes ○ No ○ Unknown

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In the eight weeks before symptom onset or diagnosis (use earlier date), did the person:

Notice any tick bites? ◯ Yes ◯ No ◯ Unknown If yes, when did the bite occur: *mm / dd / yyyy*

Where (geographic location):

Travel out of their county, state, or country of residence? ◯ Yes ◯ No ◯ Unknown

If yes, please list travel destination(s) below:

U.S. State	U.S. County	Country (international travel)	Arrival date *mm / dd / yyyy*	Departure date *mm / dd / yyyy*
U.S. State	U.S. County	Country (international travel)	Arrival date	Departure date
U.S. State	U.S. County	Country (international travel)	Arrival date	Departure date
U.S. State	U.S. County	Country (international travel)	Arrival date	Departure date
U.S. State	U.S. County	Country (international travel)	Arrival date	Departure date
U.S. State	U.S. County	Country (international travel)	Arrival date	Departure date

In the year before symptom onset or diagnosis (use earlier date), did the person:

Donate blood? ◯ Yes ◯ No ◯ Unknown

If yes, date(s) of donation: Date 1 *mm / dd / yyyy* Date 2 *mm / dd / yyyy*

Was the person a blood donor identified during transfusion investigation? ◯ Yes ◯ No ◯ Unknown

If a donated blood product was implicated in an investigation, specify which type(s) of product:

☐ Plasma ☐ Platelet ☐ Red blood cell ☐ Unknown ☐ Other:

Laboratory Testing for *Babesia*

Please include available results, especially those relevant to case classification. Enter collection date as mm/dd/yyyy.

Test 1	*Babesia* species	Date specimen collected	Result	Titer	Parasitemia (%)
Test 2	*Babesia* species	Date specimen collected	Result	Titer	Parasitemia (%)
Test 3	*Babesia* species	Date specimen collected	Result	Titer	Parasitemia (%)
Test 4	*Babesia* species	Date specimen collected	Result	Titer	Parasitemia (%)
Test 5	*Babesia* species	Date specimen collected	Result	Titer	Parasitemia (%)
Test 6	*Babesia* species	Date specimen collected	Result	Titer	Parasitemia (%)

Notes:

Instructions

Please submit form electronically to babesiosis@cdc.gov or to your local or state health department.

For submission to CDC, do not print or fax the form. If you are unable to submit this form electronically or need additional support, please contact babesiosis@cdc.gov.

The 2025 babesiosis case definition can be found here:
https://cdn.ymaws.com/www.cste.org/resource/resmgr/position_statements_files_2023/24-ID-02_Babesiosis.pdf