

Tetanus

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case
 Reviewer initials: _____
 Referred to another state: _____

CASE

Last name: _____
 First and middle name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____

Maiden name: _____ Suffix: _____

Gender: Female Male Other _____

Address line: _____

Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Zip: _____ City: _____

Marital status: Single Married Separated
 Divorced Parent with partner Widowed

State: _____ County: _____

Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian

Phone: (____)-____-____ Type: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Long-term care resident: Yes No Unknown

Parent/Guardian name: _____

Facility name: _____

Parent/Guardian phone: (____)-____-____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____

Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown

Outbreak related: Yes No Unknown

Outbreak name: _____

Exposure setting: _____

Epi-linked: Yes No Unknown

Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown

State: _____ Country: _____

Last name: _____

First name: _____

Provider title: ARNP MD DO NP PA

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____ City: _____

State: _____ County: _____

Phone: (____)-____-____ Type: _____

Healthcare provider information

LABORATORY FINDINGS - NONE**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____

Worked after symptom onset: Yes No Unknown Facility name: _____

Date worked from: ____ / ____ / ____ Address: _____

Date worked to: ____ / ____ / ____ Zip code: _____

Removed from duties: Yes No Unknown City: _____ State: _____ County: _____

Date removed: ____ / ____ / ____ Phone: (____)-____-____ Type: _____

Handle food: Yes No Unknown
 Attend or provide child care: Yes No Unknown
 Attend school: Yes No Unknown
 Work in a lab setting: Yes No Unknown

Work in a health care setting: Yes No Unknown
 Direct patient care duties in lab or health care setting: Yes No Unknown
 Health care worker type: _____

Occupation type: _____ Job title: _____

Worked after symptom onset: Yes No Unknown Facility name: _____

Date worked from: ____ / ____ / ____ Address: _____

Date worked to: ____ / ____ / ____ Zip code: _____
 Removed from duties: Yes No Unknown City: _____ State: _____ County: _____
 Date removed: ____ / ____ / ____ Phone: (____)____-____-____ Type: _____
 Handle food: Yes No Unknown Work in a health care setting: Yes No Unknown
 Attend or provide child care: Yes No Unknown Direct patient care duties in
 Attend school: Yes No Unknown lab or health care setting: Yes No Unknown
 Work in a lab setting: Yes No Unknown Health care worker type: _____

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown
 Hospital: _____ Isolated at entry: Yes No Unk Isolation type (entry): _____
 Admission date: ____ / ____ / ____ Discharge date: ____ / ____ / ____ Days hospitalized: _____
 Currently isolated: Yes No Unk Current isolation type: _____

Was this case in the intensive care unit for this disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If yes, for how many days?	_____
Outcome one month after onset:	<input type="checkbox"/> Recovered <input type="checkbox"/> Convalescing <input type="checkbox"/> Died		
If case died from tetanus, list date of death:	____ / ____ / ____		

OTHER DEMOGRAPHIC INFORMATION

If case under 28 days old at onset, collect the following information
Mother's information
 Mother's age (in years): ____ / ____ / ____ Mother's date of birth : ____ / ____ / ____ Mother's arrival in the U.S.: ____ / ____ / ____
Mother's tetanus toxoid history
 Did mother receive Tetanus toxoid before child onset: Yes No Unknown
 How long before child onset: < 6 hours 7- 23 hours 1 - 4 days 5 - 9 days 10 - 14 days 15 + days
 Years since last dose: _____
Infant's information
 Birthplace of infant: Hospital Home Other – see notes Unknown Delivered by: Physician Nurse
 Licensed midwife Unlicensed midwife
 Other – see notes Unknown

CLINICAL INFO & DIAGNOSIS

Symptoms: Generalized spasms Painful muscle spasms
Type of tetanus disease: Cephalic Localized Generalized Unknown/Other _____
Pre-existing wound 21 days prior to onset: Yes No Unk Wound location: Head Upper extremity
 Trunk Lower extremity
 Wound type: Abrasion Compound fracture Linear laceration
 Avulsion Crush Puncture
 Burn Frostbite Stellate laceration
 Wound depth: 1 cm or less More than 1 cm Signs of infection: Yes No Unk Contaminated: Yes No Unk
 Devitalized, ischemic, or denervated tissue: Yes No Unk Date wound occurred: ____ / ____ / ____
 Setting: Automobile Petting zoo Farm/yard Work Home Other indoor/outdoor setting: _____
 Other details: _____
Health care provider visited: Yes No Unk
Wound debridement performed: Yes No Unk How soon after the injury: <6 hours 1-4 days 10-14 days
 6-23 hours 5-9 days 15+ days
 Performed by a healthcare provider: Yes No Unk **Other associated conditions:** Abscess Blister Cellulitis
 Ulcer Gangrene Other None

TREATMENT

Antibiotics prescribed? Yes No Unknown

Antibiotic: _____
Date started: ____/____/____
Dose: _____
Unit: mg ml # of days: _____
of times a day: _____ Route: _____

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Date started: ____/____/____
Dose: _____
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Date started: ____/____/____
Dose: _____
Unit: mg ml # of days: _____
of times a day: _____ Route: _____

For the illness, were any of the following treatments required:

Ventilator: Yes No Unk Duration in days: _____

Tetanus immune globulin (TIG) received? Yes No Unknown

How soon after the injury: < 6 hours 7 - 23 hours 1 - 4 days 5 - 9 days 10 - 14 > 15 days days

How soon after onset: < 6 hours 7 - 23 hours 1 - 4 days 5 - 9 days 10 - 14 > 15 days days

Date started: _____ Number of days: _____
Dose: _____ Unit: _____ Number of times each day: _____
Route: _____

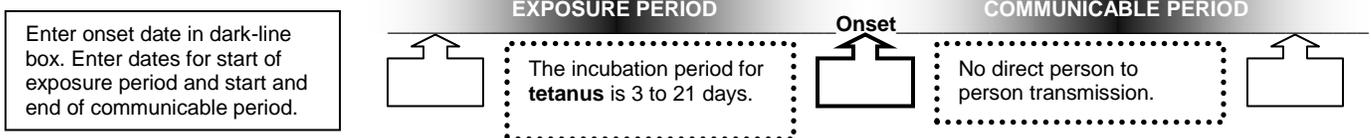
Tetanus toxoid received before onset? Yes No Unknown

Date started: _____ Number of days: _____
Dose: _____ Unit: _____ Number of times each day: _____
Route: _____

Therapeutic medication prescribed: Yes No Unk List medications: _____

Days in ICU: _____

INFECTION TIMELINE



RISK FACTORS/TRAVEL

Street drugs or steroids injected: Yes No Unknown

Ever served in the Military or National Guard? Yes No Unknown

If yes, what was your year of entry? _____

Vaccinated for tetanus: Yes No Unknown

Date vaccinated: ____/____/____ Date vaccinated: ____/____/____ Date vaccinated: ____/____/____
Lot #: _____ Lot #: _____ Lot #: _____
Vaccine type: _____ Vaccine type: _____ Vaccine type: _____
Manufacturer: _____ Manufacturer: _____ Manufacturer: _____

Number of vaccinations: _____

Does this case have diabetes: Yes No Unk Insulin dependent: Yes No Unk

NOTES:

