Anthrax

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:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown

Facility name:
Facility phone: ( )- - Type:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Parent/Guardian 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
Date of death / /
Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
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:

Healthcare provider information

Last name:
First name:
Title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP

Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other
Organism: Type (e.g. serogroup):

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other
Organism: Type (e.g. serogroup):

Laboratory: _____ Accession #: _____ Collection date: / /

Date received: / / Specimen source: _____ Test type: _____

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: Type (e.g. serogroup): ☐ Other _____

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 healthcare settings: ☐ 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

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 healthcare settings: ☐ 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:

CLINICAL INFO & DIAGNOSIS

Anthrax type:
☐ Cutaneous
☐ Gastrointestinal
☐ Pulmonary

Symptoms:
☐ Abdominal pain ☐ Black eschar (necrotic area) ☐ Chest pain ☐ Chills ☐ Cough ☐ Diarrhea ☐ Edema ☐ Erythema ☐ Fever ☐ Itching ☐ Malaise ☐ Muscle pain ☐ Nausea ☐ Swollen lymph nodes ☐ Shortness of breath ☐ Vomiting ☐ Other _____

Pre-existing wound 7 days prior to onset? ☐ Yes ☐ No ☐ Unk

Wound location: ☐ Head ☐ Trunk ☐ Upper extremity ☐ Lower extremity

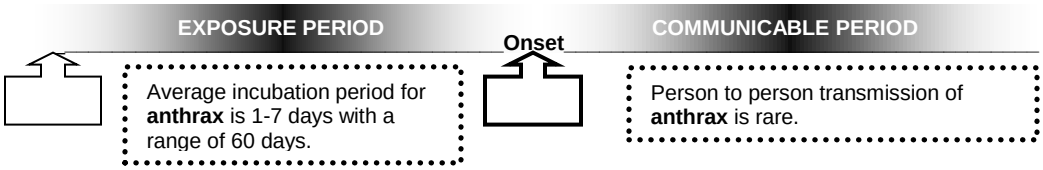
Chest x-ray done? ☐ Yes ☐ No ☐ Unk

Widened mediastynum: ☐ Yes ☐ No ☐ Unk

Date: / / Results: _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



OTHER LABORATORY FINDINGS

Biopsy performed?
☐ Yes ☐ No ☐ Unknown Date : / / Site: Result:

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

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

RISK FACTORS/TRAVEL

Vaccinated for anthrax? ☐ Yes ☐ No ☐ Unknown

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

Number of vaccinations: ____

In the 7 days prior to the onset of the symptoms has the case:

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: — Departure date: / / — Return date: / /

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk — State: — City: — Departure date: / / — Return date: / /

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: — Departure date: / / — Return date: / /

Mail handled or opened? ☐ Yes ☐ No ☐ Unk — Mail suspicious: ☐ Yes ☐ No ☐ Unk — Setting: ☐ Home ☐ School ☐ Work

From date: / / To date: / /

Worked in broadcast or print media? ☐ Yes ☐ No ☐ Unk — From date: / / To date: / /

Animal hide, hair, or bone contact? ☐ Yes ☐ No ☐ Unk — Animal: ☐ Cattle ☐ Goats ☐ Pigs ☐ Deer ☐ Horses ☐ Sheep — Contact type: ☐ Bone ☐ Hide ☐ Hair ☐ Other

From date: / / To date: / /

Ground meat consumed? ☐ Yes ☐ No ☐ Unknown

Meat fully cooked: ☐ Yes ☐ No ☐ Unknown

Source/type:

Brand name:

From date consumed: / /

To date consumed: / /

Meat other than ground meat consumed? ☐ Yes ☐ No ☐ Unknown

Meat fully cooked: ☐ Yes ☐ No ☐ Unknown

Source/type:

Brand name:

From date consumed: / /

To date consumed: / /

Worked with another case? ☐ Yes ☐ No ☐ Unknown From date: / / To date: / /

Lived with another case? ☐ Yes ☐ No ☐ Unknown From date: / / To date: / /

CONTACTS

Number of people living in case's household: _____ **Others with the same exposures**? ☐ Yes ☐ No ☐ Unknown

Close contacts with the same exposures

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

NOTES: