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:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

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
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:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

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
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:

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? ☐ Yes ☐ No ☐ Unk If yes, for how many days?

Outcome one month after onset: ☐ Recovered ☐ Convalescing ☐ 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 ☐ Generalized ☐ Localized ☐ Unknown/Other _____

Pre-existing wound 21 days prior to onset: ☐ Yes ☐ No ☐ Unk Wound location: ☐ Head ☐ Upper extremity ☐ Trunk ☐ Lower extremity

Wound type: ☐ Abrasion ☐ Avulsion ☐ Burn ☐ Compound fracture ☐ Crush ☐ Frostbite ☐ Linear laceration ☐ Puncture ☐ 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 ☐ Farm/yard ☐ Home ☐ Petting zoo ☐ Work ☐ 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 ☐ 6-23 hours ☐ 1-4 days ☐ 5-9 days ☐ 10-14 days ☐ 15+ days

Performed by a healthcare provider: ☐ Yes ☐ No ☐ Unk

Other associated conditions: ☐ Abscess ☐ Ulcer ☐ Blister ☐ Gangrene ☐ Cellulitis ☐ Other ☐ None

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

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

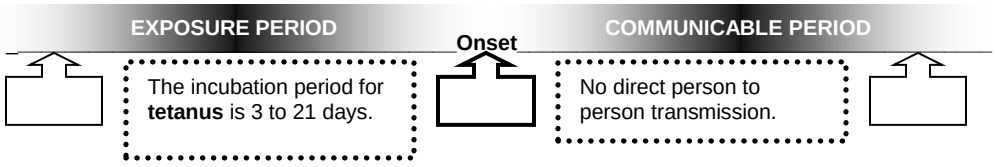
Route: _____

Therapeutic medication prescribed: ☐ Yes ☐ No ☐ Unk **List medications:** _____

Days in ICU: _____

INFECTION TIMELINE

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



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: _____