

Tetanus

PATIENT DEMOGRAPHICS

Name (last, first): _____	Birth date: __/__/____ Age: _____
Address: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
City/State/Zip: _____	Ethnicity: <input type="checkbox"/> Not Hispanic or Latino
Phone (home): _____ Phone (work) : _____	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
Occupation/grade: _____ Employer/School: _____	Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer.
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other	(Mark all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native
Name: _____ Phone: _____	<input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigator : _____	WVEDSS ID: _____
Investigator phone: _____	Case Classification:
Investigation Start Date: __/__/____	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unk

REPORTING SOURCE

Date of report: __/__/____ Report Source: Laboratory Hospital Physician Public Health Agency Other

Report Source Name: _____ Address: _____ Phone: _____

Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____

Reporter Name: _____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____

Physician Address: _____ Phone: _____

Hospital Y N U If yes: Hospital name: _____

Hospitalized for this illness? Admit date: __/__/____ Discharge date: __/__/____

Condition Illness onset date: __/__/____ Diagnosis date: __/__/____ Illness end date: __/__/____

Y N U

Is the patient pregnant?

Does the patient have pelvic inflammatory disease?

Did patient die from this illness? If yes, date of death: __/__/____

Acute wound identified? If yes, date wound occurred: __/__/____

Principal anatomic site: Head Trunk Upper extremity Lower extremity Unspecified

Was wound work related?

Location of wound causing incident: Home Farm/yard Automobile Other indoor (specify): _____

Other outdoor (specify): _____ Unknown

Describe circumstances of the injury:

Principal wound type: Abrasion Animal bite Avulsion Burn Compound fracture

Crush Dental Frost bite Insect bite/sting Linear laceration Puncture

Stellate laceration Surgery Tissue necrosis Unknown Other (specify): _____

Was wound contaminated? Y N U

Signs of infection? Y N U

Depth of wound: 1cm of less More than 1cm Unknown

Devitalized, ischemic or denervated tissue present? Y N U

Type of tetanus disease? Generalized Localized Cephalic Unknown

History of military service? Y N U

If yes, year of entry into military service: _____

Tetanus toxoid (TT) history before disease: Never 1 dose 2 doses 3 doses 4+ doses Unknown

Years since last dose: _____

Medical Care Prior to OnsetWas medical care obtained for this acute injury? Y N UTetanus toxoid (TT) or Td administered before tetanus onset? Y N UIf yes, how soon after injury? < 6 hours 7-23 hours 1-4 days 5-9 days 10-14 days 15+ days UnknownWound debrided before tetanus onset? Y N UIf yes, how soon after injury? < 6 hours 7-23 hours 1-4 days 5-9 days 10-14 days 15+ days UnknownDid patient receive Tetanus Immune Globulin (TIG)? Y N UIf yes, when was TIG administered: Before illness onset (as prophylaxis) After illness onset (as treatment)

If TIG was given as prophylaxis, how soon was it administered after the injury?

 < 6 hours 7-23 hours 1-4 days 5-9 days 10-14 days 15+ days Unknown Not administered as prophylaxis

If TIG was given as treatment, how soon was it administered after illness onset?

 < 6 hours 7-23 hours 1-4 days 5-9 days 10-14 days 15+ days Unknown Not administered as treatment

Dosage (units): _____ Days hospitalized: _____ Days in ICU: _____ Days received mechanical ventilation: _____

Associated conditions (if no acute injury):

 Abscess Blister Cancer Cellulitis Gangrene
 Gingivitis Ulcer None Unknown Other (specify): _____

Describe associated condition: _____

Is patient diabetic? Y N U if yes, insulin-dependent? Y N U Parenteral drug use? Y N U

Describe condition: _____

Outcome one month after onset? Recovered Convalescing Died**For Neonates (< 28 days old)**

Mother's age (years): _____ Mother's date of birth: __/__/____ Date of Mother's arrival in US: __/__/____

Mother's tetanus toxoid (TT) history **PRIOR** to child's disease: Never 1 dose 2 doses 3 doses 4+ doses Unknown

Years since mother's last dose: _____

Child's birthplace: Hospital Home Unknown Other(specify): _____Birth attendant(s): Physician Nurse Licensed midwife Unlicensed midwife Unknown Other (specify): _____

Other birth attendant(s) if not previously listed: _____

EPIDEMIOLOGIC

Y N U

 Is the patient associated with a daycare facility? If yes, name of day care facility: _____ Is the patient food handler? If yes, name of establishment? _____ Is this case part of an outbreak? If yes, name of outbreak? _____

Where was the disease acquired?

 Indigenous, within jurisdiction Out of country Out of jurisdiction, from another jurisdiction Out of state Unknown

Transmission mode:

 Airborne Bloodborne Dermal Foodborne Mechanical Nosocomial Sexually transmitted Transplacental transmission Vector borne Waterborne Zoonotic Indeterminate Other (specify): _____

Detection method:

 Patient self-referral Prenatal testing Prison entry screening Provider reported Routine physical Other

Confirmation method:

 Active surveillance Case/Outbreak management Clinical diagnosis (not lab confirmed) Epidemiologically linked Lab confirmed Lab report Local/State specified Medical record review No information given Occupational disease surveillance Provider certified Other (specify): _____

Confirmation date: __/__/____

PUBLIC HEALTH ACTIONS/NOTES Lost to follow-up