Washington State Department of Health

Anthrax

County

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ ☐ Years ☐ Months

Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

☐ Classification pending ☐ Confirmed ☐ Investigation in progress ☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status

☐ Complete ☐ Complete – not reportable to DOH ☐ Unable to complete Reason _____ ☐ In progress

Dates: **Investigation start** ___/___/__ Investigation complete ___/___/__ Record complete ___/___/__ **Case complete** _/___/__

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization_____

Reporter name _____ Reporter phone_____

All reporting sources (list all that apply)_____

DEMOGRAPHICS

Sex at birth: ☐ Female ☐ Male ☐ Other ☐ Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity ☐ Hispanic, Latino/a, Latinx ☐ Non-Hispanic, Latino/a, Latinx ☐ Patient declined to respond ☐ Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race ☐ Amer Ind/AK Native (***specify***: ☐ Amer Ind ***and/or*** ☐ AK Native) ☐ Asian ☐ Black or African American ☐ Native HI/Pacific Islander (***specify***: ☐ Native HI ***and/or*** ☐ Pacific Islander) ☐ White ☐ Patient declined to respond ☐ Unk

Additional race information:

☐ Afghan ☐ Afro-Caribbean ☐ Arab ☐ Asian Indian ☐ Bamar/Burman/Burmese ☐ Bangladeshi ☐ Bhutanese
☐ Central American ☐ Cham ☐ Chicano/a or Chicanx ☐ Chinese ☐ Congolese ☐ Cuban ☐ Dominican ☐ Egyptian
☐ Eritrean ☐ Ethiopian ☐ Fijian ☐ Filipino ☐ First Nations ☐ Guamanian or Chamorro ☐ Hmong/Mong
☐ Indigenous-Latino/a or Indigenous-Latinx ☐ Indonesian ☐ Iranian ☐ Iraqi ☐ Japanese ☐ Jordanian ☐ Karen
☐ Kenyan ☐ Khmer/Cambodian ☐ Korean ☐ Kuwaiti ☐ Lao ☐ Lebanese ☐ Malaysian ☐ Marshallese ☐ Mestizo
☐ Mexican/Mexican American ☐ Middle Eastern ☐ Mien ☐ Moroccan ☐ Nepalese ☐ North African ☐ Oromo
☐ Pakistani ☐ Puerto Rican ☐ Romanian/Rumanian ☐ Russian ☐ Samoan ☐ Saudi Arabian ☐ Somali
☐ South African ☐ South American ☐ Syrian ☐ Taiwanese ☐ Thai ☐ Tongan ☐ Ugandan ☐ Ukrainian
☐ Vietnamese ☐ Yemeni ☐ Other: _____

What is your (your childs) preferred language? Check one:

☐ Amharic ☐ Arabic ☐ Balochi/Baluchi ☐ Burmese ☐ Cantonese ☐ Chinese (unspecified) ☐ Chamorro ☐ Chuukese
☐ Dari ☐ English ☐ Farsi/Persian ☐ Fijian ☐ Filipino/Pilipino ☐ French ☐ German ☐ Hindi ☐ Hmong ☐ Japanese
☐ Karen ☐ Khmer/Cambodian ☐ Kinyarwanda ☐ Korean ☐ Kosraean ☐ Lao ☐ Mandarin ☐ Marshallese ☐ Mixteco
☐ Nepali ☐ Oromo ☐ Panjabi/Punjabi ☐ Pashto ☐ Portuguese ☐ Romanian/Rumanian ☐ Russian ☐ Samoan
☐ Sign languages ☐ Somali ☐ Spanish/Castilian ☐ Swahili/Kiswahili ☐ Tagalog ☐ Tamil ☐ Telugu ☐ Thai ☐ Tigrinya
☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ Other language: _____ ☐ Patient declined to respond ☐ Unknown

Interpreter needed ☐ Yes ☐ No ☐ Unk

Case Name _____ LHJ Case ID _____

EMPLOYMENT AND SCHOOL

Employed ☐ Yes ☐ No ☐ Unk Occupation _____ Industry _____

Employer _____ Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk

Type of school ☐ Preschool/day care ☐ K-12 ☐ College ☐ Graduate School ☐ Vocational ☐ Online ☐ Other

School name _____ School address _____

City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____

OK to talk to patient (If Later, provide date) ☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___ ☐ Complete ☐ Partial ☐ Unable to reach ☐ Patient could not be interviewed

Alternate contact: ☐ Parent/Guardian ☐ Spouse/Partner ☐ Friend ☐ Other _____

Name _____ Phone _____

Outbreak related ☐ Yes ☐ No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___

Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Clinical Features

Y N Unk

☐ ☐ ☐ **Any fever, subjective or measured** Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐ ☐ ☐ **Prodrome resembling a viral respiratory illness**
☐ ☐ ☐ **Diarrhea** (*3 or more loose stools within a 24 hour period*)
☐ ☐ ☐ **Bloody diarrhea**
☐ ☐ ☐ **Vomiting**
☐ ☐ ☐ **Anorexia (loss of appetite)**
☐ ☐ ☐ Abdominal pain or cramps
☐ ☐ ☐ **Severe abdominal pain or tenderness**
☐ ☐ ☐ **Hematemesis (vomiting blood)**
☐ ☐ ☐ **Pharyngitis (sore throat)**
☐ ☐ ☐ Cough Onset date ___/___/___
☐ ☐ ☐ Difficulty breathing

Y N Unk

☐ ☐ ☐ **Dyspnea (shortness of breath)**
☐ ☐ ☐ Chest pain
☐ ☐ ☐ **Cyanosis**
☐ ☐ ☐ Hypoxia
☐ ☐ ☐ **Acute respiratory distress**
☐ ☐ ☐ **Radiological evidence of mediastinal widening**
☐ ☐ ☐ **Radiological evidence of pleural effusion**
☐ ☐ ☐ **Meningitis/meningoencephalitis**
☐ ☐ ☐ **Coma**
☐ ☐ ☐ Lymphadenopathy Location ☐ **Postauricular** ☐ **Other cervical** ☐ Generalized ☐ Unk
☐ Other _____
☐ ☐ ☐ **Cervical edema**
☐ ☐ ☐ **Painless skin lesion developing papular through vesicular to black eschar with non-tender swollen rim**
☐ ☐ ☐ **Painless mucosal lesion in the oropharynx**
☐ ☐ ☐ **Shock**
☐ ☐ ☐ **Signs of septicemia**

Type of Anthrax

☐ ☐ ☐ **Cutaneous anthrax**
☐ ☐ ☐ **Inhalation anthrax**
☐ ☐ ☐ **Oropharyngeal anthrax**
☐ ☐ ☐ **Gastrointestinal anthrax**

Vaccination

Y N Unk

☐ ☐ ☐ Anthrax vaccine in past

Vaccine information available ☐ Yes ☐ No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Physician Reporting/Patient Health Care

Date first seen by health care provider ___/___/___ Location where first seen _____

Hospitalization

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Disposition ☐ Another acute care hospital Facility name _____

☐ Died in hospital

☐ Long term acute care facility Facility name _____

☐ Long term care facility Facility name _____

☐ Non-healthcare (home) ☐ Unk ☐ Other _____

☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

☐ ☐ ☐ Mechanical ventilation or intubation required

☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk

☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*

☐ ☐ ☐ Autopsy performed

☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition

Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital) ☐ Emergency department (ED)

☐ Inpatient ward ☐ ICU ☐ Other _____

RISK AND RESPONSE (Ask about exposures [1-60 days for inhalation, 1-12 days for cutaneous, and 1-7 days for gastrointestinal or oropharyngeal] before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____

☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness Ill contact's onset date ___/___/___

Contact setting/relationship to case ☐ Common Event ☐ Common meal ☐ Day care ☐ Female sexual partner

☐ Male sexual partner ☐ Friend ☐ Household contact ☐ Workplace

☐ Travel contact ☐ Other _____

☐ ☐ ☐ Outdoor or recreational activities (e.g., lawn mowing, gardening, hunting, hiking, camping, sports, yard work)

Activity ☐ Outdoor recreation ☐ Cabin ☐ Hunting ☐ Lawn mowing ☐ Other _____

☐ ☐ ☐ Consumed raw or undercooked meat Date ___/___/___

☐ ☐ ☐ Wildlife or wild animal exposure

☐ ☐ ☐ Hunted or skinned animals

☐ ☐ ☐ Contact with animal carcass Date ___/___/___

☐ ☐ ☐ Contact with unprocessed animal products (e.g., hide, hair, will, meat) Date ___/___/___

☐ ☐ ☐ Bone

☐ ☐ ☐ Hair

☐ ☐ ☐ Hide

☐ ☐ ☐ Raw meat

☐ ☐ ☐ Wool

☐ ☐ ☐ Any contact with animals at home or elsewhere

☐ ☐ ☐ Cattle, cow or calf

☐ ☐ ☐ Goat

☐ ☐ ☐ Sheep

☐ ☐ ☐ Other _____

☐ ☐ ☐ Inhalation of dust from soil, grain, or hay

☐ ☐ ☐ Injected drugs not prescribed by a doctor, even if only once or a few times Describe _____

☐ ☐ ☐ (Potential) Occupational exposure

Y N Unk
☐ ☐ ☐ Lab worker
☐ ☐ ☐ Agricultural worker
☐ ☐ ☐ Work with animals or animal products (e.g., research, veterinary medicine, slaughterhouse)
Animal _____
☐ ☐ ☐ Wildlife worker
☐ ☐ ☐ Veterinarian
☐ ☐ ☐ Other _____
☐ ☐ ☐ Works handling/opening mail, packages, shipments Location _____
Date handled suspicious mail ___/___/___ Date in room with suspicious mail ___/___/___
☐ ☐ ☐ Nearby when suspicious mail opened Date ___/___/___

Exposure and Transmission Summary

Y N Unk
☐ ☐ ☐ **Epi-linked to a documented anthrax environmental exposure**
☐ ☐ ☐ Epidemiologic link to a confirmed human case
☐ ☐ ☐ Epidemiologic link to a documented exposure

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____
☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Foodborne ☐ Animal related ☐ Person to person ☐ Unk
☐ Other _____
Describe _____

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Exposure summary

Suspected transmission type ☐ Person to person ☐ Unk ☐ Other _____

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other_____
Describe _____

Public Health Issues

Y N Unk
☐ ☐ ☐ Follow-up to assess exposure of laboratorians to specimen
☐ ☐ ☐ Attended social gatherings or crowded settings
☐ ☐ ☐ Potential bioterrorism exposure
☐ ☐ ☐ Notify FBI or public safety

Public Health Interventions/Actions

Y N Unk
☐ ☐ ☐ Notified blood or tissue bank (if recent donation)
☐ ☐ ☐ Notified Department of Agriculture or Department of Wildlife
☐ ☐ ☐ Educate on proper disposal of animal carcass
☐ ☐ ☐ Biohazard issue identified
☐ ☐ ☐ Biohazard protocol followed
☐ ☐ ☐ Follow-up on prophylaxis of exposed lab workers
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action _____

TREATMENT

Y N Unk
☐ ☐ ☐ Did patient receive prophylaxis/treatment
Specify antibiotic _____ Number of days actually taken _____
Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribed dose _____ ☐ g ☐ mg ☐ ml Duration _____ ☐ Days ☐ Weeks ☐ Months
Indication ☐ PEP ☐ Treatment for disease ☐ Incidental ☐ Other _____
Did patient take medication as prescribed ☐ Yes ☐ No - Why not _____ ☐ Unk
Prescribing provider _____

NOTES

LAB RESULTS

Lab report information
Lab report reviewed – LHJ ☐
WDRS user-entered lab report note

Submitter _____
Performing lab for entire report _____
Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date ___/___/___ Specimen received date ___/___/___
WDRS specimen type _____
WDRS specimen source site _____
WDRS specimen reject reason _____

Test performed and result
WDRS test performed _____
WDRS test result, coded _____
WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____
WDRS unit of measure _____
Test method _____
WDRS interpretation code _____
Test result – Other, specify _____
WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
Upload document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____

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