



# 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 child's) 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

**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 \_\_\_\_\_°F
- 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
<b>Travel out of</b>	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> 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  PendingTest 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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