



Tetanus

County _____

Case name (last, first) _____
 Birth date ___/___/___ Sex at birth F M Other 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
 Not reportable Probable Ruled out Suspect
 Investigation status
 In progress
 Complete
 Complete – not reportable to DOH
 Unable to complete Reason _____
 Investigation start date ___/___/___
 Investigation complete date ___/___/___
 Case complete date ___/___/___
 Outbreak related Yes No
 LHJ Cluster ID _____ Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ Years Months
Ethnicity Hispanic or Latino Not Hispanic or Latino Unk
Race (check all that apply) Unk Amer Ind/AK Native
 Asian Black/African Amer Native HI/other PI
 White Other _____
 Primary language _____
 Interpreter needed Yes No Unk
 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 _____

REPORT SOURCE

Initial report source _____
 LHJ _____
 Reporter organization _____
 Reporter name _____
 Reporter phone _____
 All reporting sources (list all that apply)

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 _____
 Contact name _____
 Contact phone _____

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
 Hypertonia
 Painful muscle spasms
 Opisthotonus (whole back spasm and bowing)
 Risus sardonicus (facial muscle spasm)

Predisposing Conditions

Y N Unk
 Diabetes mellitus
 Immunosuppressive therapy, condition, or disease Specify _____

Vaccination

Y N Unk
 Ever received a tetanus containing vaccine Number of tetanus doses prior to illness _____

Vaccine information available Yes No

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

Vaccine lot number _____ Administering provider _____

Information source Washington Immunization Information System (WIIS) WIIS ID number _____

Medical record Patient vaccination card Verbal only/no documentation Other state IIS

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

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Y N Unk

Tetanus vaccination up to date for age per ACIP

Vaccine series not up to date reason

- Religious exemption Medical contraindication Philosophical exemption
- Laboratory confirmation of previous disease MD diagnosis of previous disease
- Underage for vaccine Parental refusal Other Unknown

Physician Reporting/Patient Health Care

Y N Unk

Diagnosis of tetanus by a health care provider

Hospitalization

Y N Unk

- Hospitalized at least overnight for this illness Facility name _____
- Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
- 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 3-21 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<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 _____
- Neonate Age of mother _____ Date of birth ___/___/___ Date of last maternal tetanus dose ___/___/___
 Attended by Physician Nurse Licensed midwife Other birth attendant Unk
 Other _____
- Location of birth Home Hospital Other _____
- Mother received tetanus toxoid during the pregnancy
- Injected drugs not prescribed by a doctor, even if only once or a few times Describe _____
- Acute wound identified Date identified ___/___/___ Depth of wound 1 cm or less More than 1 cm Unk
 Environment of injury _____ Circumstances _____
- Signs of infection
- Wound contaminated
- Wound debrided before tetanus onset How soon after injury _____
 Wound site Head Trunk Upper extremity Lower extremity Unspecified
 Other _____
- Wound type Abrasion Animal bite Avulsion Burn Compound fracture Crushing injury
 Dental procedure Frostbite Insect bite/sting Linear laceration Punctate
 Stellate laceration Surgical incision Tissue necrosis Unk
 Other _____
- Was medical care obtained for this acute injury
- Tetanus toxoid (TT/Td/Tdap) administered before tetanus onset How soon after injury _____
- If no acute injury, associated condition
 Lesion type Abscess Ulcer Blister Gangrene Cellulitis Cancer Gingivitis
 None Unk Other _____
- Work related

Exposure and Transmission Summary

- 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
- Exposure summary _____

TREATMENT

Y N Unk

- Tetanus IG given prior to onset Date/time given ___/___/___ :___ AM PM Dosage (units) _____
 How soon after injury <6 hours 7-23 hours 1-4 days 5-9 days 10-14 days 15+ days Unk

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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____