



Tetanus

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 _____ LHM Case ID (optional) _____

LHM 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 _____ LHM _____

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

- 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

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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 Ukn Other _____
- Work related

Exposure and Transmission SummaryLikely geographic region of exposure In Washington – county _____ Other state _____ Not in US - country _____ UnkInternational 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 _____

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