Washington State Department of HEALTH

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 _____ 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
☐ ☐ ☐ **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:	☐ 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 _____

☐ ☐ ☐ 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 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 ☐ 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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