

Tetanus

COUNTY

FOR STATE USE ONLY

___/___/___ case report

confirmed

___/___/___ interstate

presumptive

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County Zip

_____ e-mail address _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

Lab Infection Control Practitioner
 Physician _____

Name _____

Phone _____

Date ___/___/___ Time ___:___ am
(first report) pm

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX female male

HISPANIC yes no unknown

Worksites/school/daycare _____

DATE OF BIRTH ___/___/___
m d y

RACE

White American Indian
 Black Asian/Pacific Islander
 unknown refused to answer
 other _____

Occupations/grade _____

or, if unknown, AGE _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Acute wound ONSET ___/___/___ Date wound occurred ___/___/___ Principal anatomic site: _____

Work related? yes no unk Environment: home other indoors farm/yard automobile other outdoors unk

Notes _____

Principal wound type

puncture avulsion animal bite insect bite/sting tissue necrosis unknown other, (e.g., with cancer) specify _____
 stellate laceration burn frostbite unknown other, (e.g., with cancer) specify _____
 linear laceration compound fracture unknown other, (e.g., with cancer) specify _____
 crush compound fracture unknown other, (e.g., with cancer) specify _____
 abrasion surgery unknown other, (e.g., with cancer) specify _____

Depth of wound ≤1 cm >1 cm unk
Wound contaminated? yes no unk
Signs of infection? yes no unk
Devitalized, ischemic, or denervated tissue present? yes no unk

MEDICAL CARE

Was medical care obtained for this acute injury?
 yes no unk

Was tetanus toxoid (TT) or TD administered before tetanus onset?
 yes no unk

If yes, TT or TD given how soon after injury?
 <6 hours 7-23 hours
 1-4 days 5-9 days
 10-14 days 15+ days
 unk

Was wound debrided before tetanus onset?
 yes no unk

If yes, debrided how soon after injury?
 <6 hours 7-23 hours
 1-4 days 5-9 days
 10-14 days 15+ days
 unk

Was tetanus immune globulin (TIG) prophylaxis received before tetanus onset?

yes no unk

If yes, TIG given how soon after injury?

<6 hours 7-23 hours
 1-4 days 5-9 days
 10-14 days 15+ days
 unk

Dosage (units) _____

Associated condition (if no acute injury)

abscess other infection
 ulcer cancer
 blister gingivitis
 gangrene none
 cellulitis unk

Diabetes?

yes no unk

If yes, insulin-dependent?

yes no unk

Parenteral drug abuse?

yes no unk

CLINICAL COURSE

Type of tetanus disease

generalized localized
 cephalic unk

TIG therapy given?

yes no unk

If yes, TIG given how soon after illness?

<6 hours 7-23 hours
 1-4 days 5-9 days
 10-14 days 15+ days
 unk Dosage (units) _____

Hospitalized? yes no

if yes, where _____

Admit date ___/___/___

Length of stay ___ days Days in ICU _____

Days on mechanical ventilation _____

Outcome one month after onset

recovered convalescing
 died date expired ___/___/___



PATIENT'S NAME ▶

Tetanus-containing vaccine received in past yes no unknown
 if yes, complete table:

Vaccine	Date	Provider/Phone	Verified
_____	___/___/___	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/> <input type="checkbox"/>

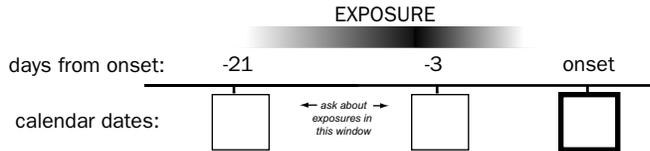
if not vaccinated, why not?

If available, provide details.

- age less than 2 months
- medical exemption
- religious objection
- "forgot"
- cost too much
- inconvenience
- concurrent illness
- other _____

INFECTION TIMELINE

Enter symptom onset date in heavy box. Count forwards and backwards to figure probable exposure period.



CASE MANAGEMENT — NEONATAL INFECTION

MATERNAL DATA

MOTHER'S DATE OF BIRTH ___/___/___
 or, if unknown, AGE _____

MOTHER'S DATE OF ARRIVAL IN U.S. ___/___/___

Tetanus toxoid (TT) administered to mother PRIOR to child's disease?

- yes no/never unk

If yes, history of known doses only

- 1 dose 2 doses
 3 doses 4 doses

Years since mother's last dose _____

NEONATE DATA

Child's birthplace
 hospital home unknown other _____

Birth attendant(s)
 physician nurse licensed midwife
 unknown other _____

Other birth attendants (not previously listed):

Comments

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Date and time case report sent to OHS: ____/____/____ ____ am pm

Completed by _____ Date _____ Phone _____ Investigation sent to OHS on ____/____/____

