West Virginia Bureau for Public Health
Department of Health & Human Resources
Your Health Your Safety Our Purpose

# Tetanus

## PATIENT DEMOGRAPHICS

Name (last, first): ______________________________________________
Address: ______________________________________________
City/State/Zip: ______________________________________________
Phone (home): ________________ Phone (work) : _________________
Occupation/grade:____________________ Employer/School:_________________
*Alternate contact:* ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:* ___________________________ *Phone:* ___________________________

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

## INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): __________________________
Investigator : _________________________
Investigator phone: _________________
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: __________________
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unk

## REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _________________________ Address: ___________________________ __________ Phone: _____________
Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____
Reporter Name: _____________________ ____ Address: __________________________________________ Phone: _____________

## CLINICAL

Physician Name: ______________________ Physician Facility : _____________________________________________________
Physician Address: _______________________________________________________________ Phone: ______________________

**Hospital** **Y N U**
☐ ☐ ☐ Hospitalized for this illness? If yes: Hospital name: ______________________________________
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

**Condition** Illness onset date: __ / __ / ____ Diagnosis date: __ / __ / ____ Illness end date: __ / __ / ____

**Y N U**
☐ ☐ ☐ Is the patient pregnant?
☐ ☐ ☐ Does the patient have pelvic inflammatory disease?
☐ ☐ ☐ Did patient die from this illness? If yes, date of death: __/__/____
☐ ☐ ☐ Acute wound identified? If yes, date wound occurred: __/__/____
Principal anatomic site: ☐ Head ☐ Trunk ☐ Upper extremity ☐ Lower extremity ☐ Unspecified
☐ ☐ ☐ Was wound work related?
Location of wound causing incident: ☐ Home ☐ Farm/yard ☐ Automobile ☐ Other indoor (specify): ________________
☐ Other outdoor (specify): ____________________ ☐ Unknown

Describe circumstances of the injury:
______________________________________________________________________________________________
______________________________________________________________________________________________

Principal wound type: ☐ Abrasion ☐ Animal bite ☐ Avulsion ☐ Burn ☐ Compound fracture
☐ Crush ☐ Dental ☐ Frost bite ☐ Insect bite/sting ☐ Linear laceration ☐ Puncture
☐ Stellate laceration ☐ Surgery ☐ Tissue necrosis ☐ Unknown ☐ Other (specify): ___________________

Was wound contaminated? ☐ **Y** ☐ **N** ☐ **U**
Signs of infection? ☐ **Y** ☐ **N** ☐ **U**
Depth of wound: ☐ 1cm of less ☐ More than 1cm ☐ Unknown
Devitalized, ischemic or denervated tissue present? ☐ **Y** ☐ **N** ☐ **U**

Type of tetanus disease? ☐ Generalized ☐ Localized ☐ Cephalic ☐ Unknown

History of military service? ☐ **Y** ☐ **N** ☐ **U**
If yes, year of entry into military service: ________

Tetanus toxoid (TT) history before disease: ☐ Never ☐ 1 dose ☐ 2 doses ☐ 3 doses ☐ 4+ doses ☐ Unknown
Years since last dose:_______

**Medical Care Prior to Onset**

Was medical care obtained for this acute injury? ☐ **Y** ☐ **N** ☐ **U**

Tetanus toxoid (TT) or Td administered before tetanus onset? ☐ **Y** ☐ **N** ☐ **U**

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

Wound debrided before tetanus onset? ☐ **Y** ☐ **N** ☐ **U**

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

Did patient receive Tetanus Immune Globulin (TIG)? ☐ **Y** ☐ **N** ☐ **U**

If yes, when was TIG administered: ☐ Before illness onset (as prophylaxis) ☐ After illness onset (as treatment)

If TIG was given as prophylaxis, how soon was it administered after the injury?

☐ < 6 hours ☐ 7-23 hours ☐ 1-4 days ☐ 5-9 days ☐ 10-14 days ☐ 15+ days ☐ Unknown ☐ Not administered as prophylaxis

If TIG was given as treatment, how soon was it administered after illness onset?

☐ < 6 hours ☐ 7-23 hours ☐ 1-4 days ☐ 5-9 days ☐ 10-14 days ☐ 15+ days ☐ Unknown ☐ Not administered as treatment

Dosage (units): _______ Days hospitalized: _______ Days in ICU: _______ Days received mechanical ventilation: _______

Associated conditions (if no acute injury):

☐ Abscess ☐ Blister ☐ Cancer ☐ Cellulitis ☐ Gangrene

☐ Gingivitis ☐ Ulcer ☐ None ☐ Unknown ☐ Other (specify): ____________________

Describe associated condition: ____________________________________________________________

Is patient diabetic? ☐ **Y** ☐ **N** ☐ **U** if yes, insulin-dependent? ☐ **Y** ☐ **N** ☐ **U** Parenteral drug use? ☐ **Y** ☐ **N** ☐ **U**

Describe condition: ____________________________________________________________

Outcome one month after onset? ☐ Recovered ☐ Convalescing ☐ Died

**For Neonates (< 28 days old)**

Mother's age (years): ____ Mother's date of birth: __/__/____ Date of Mother's arrival in US: __/__/____

Mother's tetanus toxoid (TT) history **PRIOR** to child's disease:

☐ Never ☐ 1 dose ☐ 2 doses ☐ 3 doses ☐ 4+ doses ☐ Unknown

Years since mother's last dose: _______

Child's birthplace: ☐ Hospital ☐ Home ☐ Unknown ☐ Other(specify): _________________________

Birth attendant(s): ☐ Physician ☐ Nurse ☐ Licensed midwife ☐ Unlicensed midwife ☐ Unknown ☐ Other (specify): ____________

Other birth attendant(s) if not previously listed: ____________________________________________________

## EPIDEMIOLOGIC

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Is the patient associated with a daycare facility? If yes, name of day care facility: ________________________________ |
| ☐ | ☐ | ☐ | Is the patient food handler? If yes, name of establishment? _____________________________ |
| ☐ | ☐ | ☐ | Is this case part of an outbreak? If yes, name of outbreak? _____________________________________ |

Where was the disease acquired?

☐ Indigenous, within jurisdiction ☐ Out of country ☐ Out of jurisdiction, from another jurisdiction ☐ Out of state ☐ Unknown

Transmission mode:

☐ Airborne ☐ Bloodborne ☐ Dermal ☐ Foodborne ☐ Mechanical ☐ Nosocomial ☐ Sexually transmitted

☐ Transplacental transmission ☐ Vector borne ☐ Waterborne ☐ Zoonotic ☐ Indeterminate ☐ Other (specify): ______________

Detection method:

☐ Patient self-referral ☐ Prenatal testing ☐ Prison entry screening ☐ Provider reported ☐ Routine physical ☐ Other

Confirmation method:

☐ Active surveillance ☐ Case/Outbreak management ☐ Clinical diagnosis (not lab confirmed) ☐ Epidemiologically linked

☐ Lab confirmed ☐ Lab report ☐ Local/State specified ☐ Medical record review

☐ No information given ☐ Occupational disease surveillance ☐ Provider certified ☐ Other (specify): _______________________

Confirmation date: __/__/____

## PUBLIC HEALTH ACTIONS/NOTES

☐ Lost to follow-up