North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

TETANUS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 40

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
Specify:

Clinical classification:
☐ Cephalic
☐ Generalized
☐ Localized
☐ Unknown

Recent wound identified? ☐Y ☐N ☐U
Date wound occurred_____
Principal anatomic site:
☐ Head ☐ Lower Extremities
☐ Trunk ☐ Unspecified
☐ Upper Extremities
Work-related ☐Y ☐N ☐U
Environment:
☐ Home ☐ Automobile
☐ Other indoors ☐ Other outdoors
☐ Farm/Yard ☐ Unknown
Specify and give details:

Principal wound type:
☐ Puncture ☐ Compound fracture
☐ Stellate laceration ☐ Other (e.g. with cancer)
Specify:
☐ Linear laceration ☐ Surgery
☐ Crush ☐ Animal bite
☐ Abrasion ☐ Insect bite/Sting
☐ Avulsion ☐ Dental
☐ Burn ☐ Tissue necrosis
☐ Frostbite ☐ Unknown
Wound contaminated? ☐Y ☐N ☐U
Diabetes ☐Y ☐N ☐U
Is the patient on insulin? ☐Y ☐N ☐U

INFANT BIRTH DETAILS
COMPLETE IF PATIENT IS A NEONATE (<28 DAYS OLD)
Child's birthplace
☐ Hospital
☐ Home
☐ Other
☐ Unknown
Birth attendant(s)
☐ Physician
☐ Nurse
☐ Licensed midwife
☐ Unlicensed midwife
☐ Unknown
☐ Other: _____
Hospital or facility where child was born
Street address of child's residence at time of birth:
_____
City/Town of child's residence at time of birth:
_____
State_____Zip code _____
Country _____
Infant gestational age at birth:
☐ Full term ☐ Premature ☐ Unknown
Number of weeks gestation:_____
Birth weight:_____
Birth weight unit
☐ Grams ☐ Pounds/ounces ☐ Birth weight unknown

MATERNAL INFORMATION
Date of birth of biologic mother_____
If date of birth is unknown, provide biologic mother's age in years_____
Date of biologic mother's arrival in the US (mm/dd/yyyy):_____
Was the child's biologic mother immunized with vaccine against this specific disease? ☐Y ☐N ☐U
Type of vaccine: _____
Vaccine date: _____
Type of vaccine: _____
Vaccine date: _____
Type of vaccine: _____
Vaccine date: _____
Type of vaccine: _____
Vaccine date: _____
Type of vaccine: _____
Vaccine date: _____
Type of vaccine: _____
Vaccine date: _____

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____
ICU admission? ☐Y ☐N ☐U

TREATMENT
Did the patient require mechanical ventilation? ☐Y ☐N ☐U
Number of days on mechanical ventilation_____
Was the wound debrided before tetanus onset? ☐Y ☐N ☐U
How soon was wound debrided after injury?
☐ < 6 hours
☐ 7-23 hours
☐ 1-4 days
☐ 5-9 days
☐ 10-14 days
☐ 15+ days
☐ Unknown
Was tetanus immune globulin (TIG) PROPHYLAXIS received before tetanus onset? ☐Y ☐N ☐U
How soon was TIG given after injury?
☐ < 6 hours
☐ 7-23 hours
☐ 1-4 days
☐ 5-9 days
☐ 10-14 days
☐ 15+ days
☐ Unknown
Specify dosage:_____
Was TIG THERAPY given? ☐Y ☐N ☐U
How soon after illness onset was TIG given?
☐ < 6 hours
☐ 7-23 hours
☐ 1-4 days
☐ 5-9 days
☐ 10-14 days
☐ 15+ days
☐ Unknown Specify dosage:_____
Discharge/Final diagnosis:_____
_____
Survived? ☐Y ☐N ☐U

(CONTINUED NEXT PAGE)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE (CONTINUED)

Outcome one month after onset:
- ☐ Fully recovered
- ☐ Survived but experiencing sequelae (residual deficit from illness) at time of report

Died? ☐ Y ☐ N ☐ U
Died from this illness? ☐ Y ☐ N ☐ U
Death date (mm/dd/yyyy): _____
Patient died in North Carolina? ☐ Y ☐ N ☐ U
County of death: _____
Died outside NC? ☐ Y ☐ N ☐ U
Specify where: _____
Autopsy performed? ☐ Y ☐ N ☐ U
Facility where autopsy was performed: _____
Patient autopsied in NC? ☐ Y ☐ N ☐ U
County of autopsy: _____
☐ Autopsied outside NC, specify where: _____
Source of death information (select all that apply):
Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.
- ☐ Death certificate
- ☐ Autopsy report final conclusions
- ☐ Hospital/physician discharge summary
- ☐ Other: _____

Cause of death: _____

RISK
Parenteral drug abuse? ☐ Y ☐ N ☐ U
If yes, describe condition:

Occupation: _____

History of Military Service (Active or Reserve ☐ Y ☐ N ☐ U
Year of entry into military service: _____

VACCINE
Has patient/contact ever received tetanus-containing vaccine? ☐ Y ☐ N ☐ U

Vaccine #1
Date of vaccination(mm/dd/yyyy) _____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____

Vaccine #2
Date of vaccination(mm/dd/yyyy) _____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____

Vaccine #3
Date of vaccination(mm/dd/yyyy) _____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____

Vaccine #4
Date of vaccination(mm/dd/yyyy) _____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____

Vaccine #5
Date of vaccination(mm/dd/yyyy) _____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____

Reason for inadequate vaccination:
- ☐ Religious exemption
- ☐ Medical exemption
- ☐ Medical contraindication
- ☐ Philosophical exemption (outside NC only)
- ☐ Laboratory evidence of previous disease
- ☐ Physician diagnosis of previous disease
- ☐ Under age for vaccination
- ☐ Parental refusal
- ☐ Missed opportunities
- ☐ Unknown
- ☐ Other, specify: _____

Source of vaccine information:
- ☐ Patient's or Parent's verbal report
- ☐ Physician
- ☐ Medical record
- ☐ Certificate of immunization record
- ☐ Patient vaccine record
- ☐ School record
- ☐ Other specify: _____
- ☐ NCIR record
- ☐ Unknown

How soon was TT or Td/Tdap given after injury that caused this illness?
- ☐ <6 hours
- ☐ 7–23 hours
- ☐ 1–4 days
- ☐ 5–9 days
- ☐ 10–14 days
- ☐ 15+ days
- ☐ Unknown

Number of doses received prior to illness: _____

Date of last tetanus containing vaccine prior to onset of this illness: _____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U
Specify _____

Did patient have other condition potentially affecting skin integrity? ☐ Y ☐ N ☐ U
Specify condition(s) (add new for all the apply)
- ☐ Abscess
- ☐ Blister
- ☐ Cancer
- ☐ Cellulitis
- ☐ Gangrene
- ☐ Gingivitis
- ☐ Ulcer
- ☐ Other infection

Describe condition:

Does the patient have dental caries? ☐ Y ☐ N ☐ U
Other underlying illness ☐ Y ☐ N ☐ U
Specify: _____

Was the patient receiving any of the following treatments or taking any medications?
Antibiotics ☐ Y ☐ N ☐ U
For what medical condition? _____
Antacids ☐ Y ☐ N ☐ U
For what medical condition? _____
Chemotherapy ☐ Y ☐ N ☐ U
If yes, was therapy within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition? _____
Radiotherapy ☐ Y ☐ N ☐ U
If yes, was therapy within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition? _____
Systemic steroids/corticosteroids, including steroids taken by mouth or injection ☐ Y ☐ N ☐ U
If yes, was medication taken within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition? _____
Immunosuppresive therapy, including anti-rejection therapy ☐ Y ☐ N ☐ U
If yes, specify: _____
If yes, was medication taken within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition? _____
Aspirin or aspirin-containing product ☐ Y ☐ N ☐ U
If yes, was medication taken within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition? _____

REASON FOR TESTING

Why was the patient tested for this condition?
- ☐ Symptomatic of disease
- ☐ Exposed to organism causing this disease (asymptomatic)
- ☐ Other, specify _____
- ☐ Unknown

PREGNANCY

Is the patient currently pregnant? ☐ Y ☐ N ☐ U
Estimated delivery date (mm/dd/yyyy): _____
Give number of weeks gestation at onset of illness: _____
Has the mother received prenatal care? ☐ Y ☐ N ☐ U
Date of first prenatal visit (mm/dd/yyyy): _____
Number of prenatal visits: _____
Prenatal provider name _____
OB Name _____
Street address _____
City _____
State _____
Zip code _____
Phone (_____) _____
Did patient attend family planning clinic prior to conception? ☐ Y ☐ N ☐ U
Has the patient ever been pregnant? ☐ Y ☐ N ☐ U
Total number of previous pregnancies of the biologic mother: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
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TREATMENT

Did patient take an antibiotic as treatment for this illness? ☐ Y ☐ N ☐ U

Specify antibiotic name:_____

Dose _____

Administration route:

- ☐ Oral
- ☐ Intravenous (IV)
- ☐ Intramuscular (IM)
- ☐ Topical
- ☐ Other_____
- ☐ Unknown

Date antibiotic began (mm/dd/yy):_____

Date antibiotic ended (mm/dd/yy):_____

Number of days taken:_____ ☐ Unknown

Has the patient ever received immune globulin? ☐ Y ☐ N ☐ U

When was the last dose received?_____

Did the patient receive medical care for this illness? ☐ Y ☐ N ☐ U

Specify level(s) of care (check all that apply):

- ☐ Outpatient
- ☐ Emergency department
- ☐ Inpatient
- ☐ Other
- ☐ Unknown

TRAVEL/IMMIGRATION

The patient is:

- ☐ Resident North Carolina
- ☐ Resident of another state or US territory
- ☐ Foreign visitor
- ☐ Refugee

Refugee camp(s)? ☐ Y ☐ N ☐ U

Name of camp_____

Location of camp_____

Country of birth _____

Last country prior to arrival in US _____

Date of entry to US _____

- ☐ Recent immigrant

Country of birth _____

Last country prior to arrival in US _____

Date of entry to US _____

- ☐ Foreign adoptee

Country of birth _____

Last country prior to arrival in US _____

Date of entry to US _____

- ☐ None of the above

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed?

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County_____

☐ Outside NC, but within US

City _____

State _____

County_____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes:

Tetanus *(Clostridium tetani)*

2010 Case Definition

CSTE Position Statement Number: 09-ID-63

Case classification

Probable:
In the absence of a more likely diagnosis, an acute illness with:

- muscle spasms or hypertonia, AND
- diagnosis of tetanus by a health care provider;

OR

Death, with tetanus listed on the death certificate as the cause of death or a significant condition contributing to death.

Comment

There is no definition for “confirmed” tetanus.