

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



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

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.

Form with fields for Patient's Last Name, First, Middle, Suffix, Maiden/Other, Alias, Birthdate (mm/dd/yyyy), and SSN.

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Main form body containing sections: Is/was patient symptomatic for this disease?, INFANT BIRTH DETAILS, Was patient hospitalized for this illness >24 hours?, TREATMENT, Clinical classification, Recent wound identified?, Principal anatomic site, Environment, Principal wound type, MATERNAL INFORMATION, and Discharge/Final diagnosis.

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: \_\_\_\_\_

**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  Gangrene  
 Blister  Gingivitis  
 Cancer  Ulcer  
 Cellulitis  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? \_\_\_\_\_

**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: \_\_\_\_\_

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? \_\_\_\_\_

Immunosuppressive 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 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:** \_\_\_\_\_

**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) / /
						SSN / /

**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

**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:

**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:

## **Tetanus (*Clostridium tetani*)**

### **1996 CDC Case Definition**

#### **Clinical case definition**

Acute onset of hypertonia and/or painful muscular contractions (usually of the muscles of the jaw and neck) and generalized muscle spasms without other apparent medical cause

#### **Case classification**

*Confirmed:* a clinically compatible case, as reported by a health-care professional