

Anthrax Case Investigation Form

Page 1 is for your records.

Please submit Page 2 to CDC within 24 hours of case identification.

Submit Pages 3-7 to CDC within 1 week of case identification, or when feasible. Please remove personally identifying information (PII) before you submit any part of the form to CDC (clicking the submit button will remove PII from the created XML file).

If a case dies within 1 week of onset, notify CDC within 24 hours of death.

State

State Case ID

State Patient ID

Medical Record ID

Case Information

First Name Last Name Phone

Address City Homeless?

State of Residence FIPS code (if known) Zip Code

County of Residence FIPS code (if known)

Country of usual residence Sex (M / F / Unk) Pregnant (No / Yes / Unk)

Birth Date Age Unit Years Months Days

Race American Indian or Alaska Native Native Hawaiian or Other Pacific Islander White Asian Black or African American Other Unknown Unknown
Ethnicity Hispanic or Latino Not Hispanic or Latino Unknown

Emergency Contact Parent/Guardian Spouse/Partner Other Contact Name Phone

Employment Location/ Information

Employer Worksite/School Name Occupation

Address City

State of Employer FIPS code (if known) Zip Code

County of Employer FIPS code (if known)

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State

State Case ID

Patient Initials

[Notification Guidelines](#)

[CDC Anthrax web site](#)

[Anthrax Case Definition](#)

24-Hour Report

Case Classification Confirmed Probable Suspected Not a Case Unknown

Classification Determined By Laboratory Results Clinical Presentation Epi Link

Suspected clinical form at admission (select all that apply):

Inhalation Gastrointestinal/ Oropharyngeal Cutaneous Injection Meningeal

Date Onset

Date State Notified

Date/ Time Local Health Dept. Notified

By

Lab ICP Other
 HCP Public Health

County Reporting

Investigator Name

Agency

Phone

HCP Name

Agency

Phone

Demographics (mirrored from page 1)

State of Residence

FIPS code (if known)

County of Residence

FIPS code (if known)

Country of usual residence

Sex (M / F / Unk)

Pregnant (No / Yes / Unk)

Birth Date

Age

Unit Years Months Days

Race American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 Asian White
 Black or African American Other Unknown

Ethnicity Hispanic or Latino
 Not Hispanic or Latino
 Unknown

Occupation

State of Employer

FIPS code (if known)

County of Employer

FIPS code (if known)

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Exposures

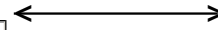
If exposure occurred via a documented exposure event, identify the event on the next line and skip the rest of this section.

Participated in incident response (e.g., environmental sampling)?

Specify exposures encountered prior to disease onset. Exposure window depends on the Clinical Form of disease

14 days prior -- Cutaneous and Injection
60 days prior -- Inhalation and Meningeal
7 days prior -- GI / Oropharyngeal
(use longest incubation window when case exhibits >1 Clinical Form)

Earliest Possible
Exposure Date



Date Symptom
Onset

No / Yes/ Unk

Exposure to livestock/ wild mammals/ their body fluids?

Specify animal(s) Describe exposure

Animal(s) disposition? Live Dead Both Unknown Date(s) of exposure -

Consumed or contact with undercooked or raw meat?

Exposure to animal products (e.g., untreated animal hair, wool, hides, and animal skin drums)?

Specify animal(s) Describe exposure

Date(s) of exposure -

Gardened or other work with soil?

If yes, was bone meal fertilizer or similar used?

Worked in a clinical or microbiological laboratory?

Exposed to unknown powder?

Handled suspicious mail?

Undiagnosed similar illness in friends, family, coworkers, or other contacts?

Consumed same food/drink as lab-confirmed anthrax case? Specify food/drink

Exposed to the same environment, animal, or objects as a lab-confirmed anthrax case?

Exposed to what? Where was the exposure?

Contact with illicit drugs? Name/Type

Received an injection?

List locations routinely visited during:

Morning

Noon

Afternoon/Evening

Night

Took public transportation (select all that apply)?

Bus Train Light Rail Subway Ferry Other: Specify

Specify route
Name or Number

Specify Date(s) Used -

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Exposures (continued)

No / Yes/ Unk

 Attended a large gathering (e.g., concert, sporting event)?

Event

Location name, city, state, zip*

Date

* Enter all information available; location name, city and state may be sufficient.

 Attended a place where people congregate (e.g., shopping mall, religious services)?

Place Name

Address, city, state, zip*

Date

* Enter all information available; location name, city and state may be sufficient.

 Traveled out of county, state, or country? (enter overflow travel in Notes section)

Destination

Date Departed

Date Returned

Vaccine and Antimicrobial Prophylaxis

No / Yes/ Unk

 Was anthrax vaccine received?If yes, what was received? 1-Post-exposure vaccine (1,2,or 3 doses) 2-Partial series of pre-exposure vaccine 3-Full series of pre-exposure vaccine If received a full series of pre-exposure vaccine, is the subject up-to-date on the annual booster vaccine?Date Last Received Doses Received 1 2 3 4 5 >5 Unk Received post-exposure antimicrobials?If yes, specify antimicrobial names Doxycycline Ciprofloxacin Amoxicillin Levfloxacin Other: Specify Date received Date ended Antimicrobials not taken or discontinued?If yes, why? Low perceived risk Adverse events Fear of side effects Other: Specify

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Clinical Presentation

Date of onset Date of diagnosis

Clinical form at admission

Inhalation
 Gastrointestinal/ Oropharyngeal
 Cutaneous
 Injection
 Meningeal

Select ALL symptoms described and signs exhibited by the patient

General (No / Yes / Unk)

Anorexia
 Cyanosis
 Fever
 Hypoxia
 Malaise/Fatigue

Inhalation (No / Yes / Unk)

Acute respiratory distress
 Chest pain
 Cough
 Dyspnea
 Hemoptysis

Cutaneous/Injection (No / Yes / Unk)

Cellulitis
 Edema
 Erythema
 Eschar
 Fasciitis
 Lymphadenopathy
 Lymphangitis
 Pruritus
 Vesicles

GI/ Oropharyngeal (No / Yes / Unk)

Abdominal pain/Tenderness
 Abdominal swelling
 Diarrhea/Vomiting
 Bloody?
 Oropharyngeal lesions
 Pharyngitis

Meningeal (No / Yes / Unk)

Altered mental status
 Coma
 Convulsions
 Headache
 Neck pain/Stiffness
 Photophobia

List chronic conditions

Laboratory Information

Laboratories Performing Diagnostics

Lab Number	Lab Name	City	State	Specimen ID
Lab 1				
Lab 2				
Lab 3				
Lab 4				

CDC DASH ID (if tested at CDC)

Select radiographic and imaging studies conducted, and findings: (No / Yes / Unk)

MRI Ascites Pleural effusion
 Chest CT Mediastinal Widening Pericardial effusion
 CXR

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Laboratory Information

Lab Performing Test Test (1,2,3,4)	Specimen	Collected Date 1	Collected before antibiotics? (No / Yes / Unk)	Positive? (No / Yes / Unk)	Collected Date 2 (convalescent)	Titer 1 1:___	Titer 2 1:___
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Treatment

No / Yes / Unk

Hospitalized? If yes, date of admission

Admitted to ICU for any length of time?

On mechanical ventilation for any length of time?

Transferred? To Facility [Name]

Final Treatment Place Phone

Address City State

Antimicrobials given for illness? If yes, enter the antimicrobials used for treatment of anthrax:

Antimicrobial Name	Other, Specify	Start Date	End Date	No. Days Taken	Route (po, iv, unk)

AIG given? Date given

Raxibacumab given? Date given

Other treatments given

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Outcome

Clinical Outcome

Date of Discharge

Date of Death

Was an autopsy performed? (No / Yes/ Unknown)

Facility

City

Notes

Updated Case Report?