

Pertussis Investigation Form

ISLAND: □ St. Croix □ St. John	FINAL STATUS:
☐ St. Thomas ☐ Water Island	□PROBABLE
	NBS PATIENT ID#: □ RULED OUT/ DROPPED
Patient's Name	Reported By:
Patient's Name: Last First Address:	Agency:
City: Estate: Zip:	Phone: ()
Region: Phone: ()	Date:/
Parent/Guardian:	Report Given to:
Physician: Phone: ()	Organization:
Address:	Phone: ()
	Date:/
DEMOGRAPHICS: DATE OF BIRTH:// AGE:	
CLINICAL:	
□Hospitalized at: Admitted:/	
Was this patient in the Intensive Care Unit (ICU)? ☐ Yes ☐ No ☐ Unknown	own Number of days patient was in ICU: days
Required mechanical ventilation? ☐ Yes ☐ No ☐ Unknown Number of day	rs patient received mechanical ventilation:days
Symptom onset date://	
Type of Tetanus: ☐ Generalized ☐ Localized ☐ Cephalic	
Acute wound identified? ☐ Yes ☐ No ☐ Unknown If YES, date wound	nd occurred:/
Work related? □Yes □ No □ Unknown	
Environment: ☐ Home ☐ Other Indoors ☐ Farm/yard/garden ☐ Automobile	e □ Other outdoors □ Construction site □ Unknown
Describe in detail circumstances of wound (e.g. stepped on a nail in basement):	
Specify one principal anatomic site: ☐ Head ☐ Trunk ☐ Upper extremity	□Lower extremity □ More than 1
Specify ONE principal wound type: ☐ Abrasion ☐ Animal bite ☐ Avulsion	n □ Body Piercing □ Burn □ Compound Fracture
☐ Crush/Blunt injury ☐ Frostbite ☐ Hun	nan Bite
☐ Linear Laceration ☐ Puncture ☐ S	tellate Laceration Surgery Tattoo
☐ Traumatic Amputation ☐ Unknown	□ Other:
Was medical care obtained for the acute wound or injury before tetanus symptom on	nset? □ Yes □ No □ Unknown
If YES, date of wound care:/	

CLINICAL cont'd:	
Was tetanus toxoid (Td, TT, DT, Tdap) administered for the acute wound or injury before tetanus symptom onset? ☐Yes ☐No ☐Unknown	
Date patient received tetanus toxoid (Td, TT, DT, Tdap):/	
Was tetanus immune globulin (TIG) prophylaxis given as part of wound care before tetanus symptom onset? □Yes □No □Unknown	
Date patient received TIG prophylaxis:/ Prophylactic TIG dosage (units):	
Were there signs of infection at the time of care for the acute wound or injury? Yes No Unknown If NO acute injury, identify associated condition: Abscess Ulcer Blister Gangrene Cellulitis Cancer Dental Infection/Gingivitis Ear Infection Injection Drug Use Other, specify	
Was medical care obtained for the non-acute condition before tetanus symptom onset: \square Yes \square No If YES, date of wound://	
Was tetanus toxoid (Td, TT, DT, Tdap) administered for the non-acute condition before tetanus symptom onset? ☐Yes ☐No ☐Unknown	
Date patient received tetanus toxoid (Td, TT, DT, Tdap):/	
TREATMENT OF TETANUS:	
Was wound infected at the time of tetanus diagnosis? ☐ Yes ☐ No ☐ Unknown	
Was TETANUS IMMUNE GLOBULIN (TIG) therapy given? □ Yes □ No □ Unknown Date received://	
Final outcome: □ Recovered □ Convalescing □ Died If deceased, DATE:/ If pt is still in ICU, intubated or otherwise still critical, please continue to monitor patient until an outcome determination can be made Was a tetanus antibody test performed? □ Yes □ No □ Unknown Date of tetanus antibody test://	
Result of tetanus antibody test :IU/mL(.01 thru 100):	
VACCINE HISTORY:	
TETANUS TOXOID(Td, TT, DT, DTaP, Tdap) history PRIOR to tetanus disease (EXCLUDE doses received since acute injury)	
□ Never Vaccinated □ 1 Dose □ 2 Doses □ 3 Doses □ 4 Doses □ Unknown Date of last dose: :/	
Interval since last TETANUS TOXOID dose:years	
If the patient is unsure about his/her tetanus vaccination history, did the patient have: □ Immunizations in childhood? □ Immunizations for school? □ Immunizations for work? □ Immunizations for military? □ Immunizations for travel? □ Immunizations for immigration? □ Immunizations for other reasons?	
If patient never received tetanus vaccination, give reason:	
EPIDEMIOLOGICAL:	
Was the patient born in the U.S.? \(\textstyle \texts	
Occupation:	
Diabetes? □Yes □No □Unknown If YES, insulin-dependent diabetes? □Yes □No □Unknown	
Intravenous drug abuse? □Yes □No □Unknown	
<u>CDC Objective</u> : 85% of vaccine preventable cases must be investigated and reported to the CDC within 30 days of initial report.	
Date Investigation Started:/Date Investigation Completed:/Date Reported to DSHS:/	
Investigator's Name:Phone :()	
Closed in NBS? □ Yes □ No If probable, notification submitted? □ Yes □ No	
COMMENTS:	