

Tetanus Surveillance Worksheet

NAME (Last, First)		Hospital Record No.			
Address (Street and No.)		City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/Lab Phone		Address			Phone

.....DETACH HERE and transmit only lower portion if sent to CDC.....

CDC NETSS ID		County		State		Zip									
Birth Date		Age		Age Type		Race		Ethnicity		Sex					
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		<input type="text"/> <input type="text"/> <input type="text"/> Unknown= 999		<input type="checkbox"/> 0 = 0-120 years <input type="checkbox"/> 1 = 0-11 months <input type="checkbox"/> 2 = 0-52 weeks		<input type="checkbox"/> 3 = 0-28 days <input type="checkbox"/> 9 = Unknown		<input type="checkbox"/> N = Native Amer./Alaska Native <input type="checkbox"/> A = Asian/Pacific Islander <input type="checkbox"/> B = African American		<input type="checkbox"/> W = White <input type="checkbox"/> O = Other <input type="checkbox"/> U = Unknown		<input type="checkbox"/> H = Hispanic <input type="checkbox"/> N = Not Hispanic <input type="checkbox"/> U = Unknown		<input type="checkbox"/> M = Male <input type="checkbox"/> F = Female <input type="checkbox"/> U = Unknown	
Event Date			Event Type			Reported			Imported		Report Status				
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year			<input type="checkbox"/> 1 = Onset Date <input type="checkbox"/> 2 = Diagnosis Date <input type="checkbox"/> 3 = Lab Test Done <input type="checkbox"/> 4 = Reported to County			<input type="checkbox"/> 5 = Reported to State or MMWR Report Date <input type="checkbox"/> 6 = Unknown			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		<input type="checkbox"/> 1 = Indigenous <input type="checkbox"/> 2 = International <input type="checkbox"/> 3 = Out of State <input type="checkbox"/> 9 = Unknown		<input type="checkbox"/> 1 = Confirmed <input type="checkbox"/> 2 = Probable <input type="checkbox"/> 3 = Suspect <input type="checkbox"/> 9 = Unknown		

HISTORY	Date Year of Onset		Acute Wound Identified?		Date Wound Occurred		Principal Anatomic Site			
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		<input type="checkbox"/> 1 = Head <input type="checkbox"/> 2 = Trunk <input type="checkbox"/> 3 = Upper Extremity <input type="checkbox"/> 4 = Lower Extremity <input type="checkbox"/> 9 = Unspecified			
	Occupation		Work Related?		Environment		Circumstances			
	History of Military Service (Active or Reserve)? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Year of Entry into Military Service <input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> 0 = Home <input type="checkbox"/> 1 = Other Indoors <input type="checkbox"/> 2 = Farm / Yard		<input type="checkbox"/> 3 = Automobile <input type="checkbox"/> 4 = Other Outdoors <input type="checkbox"/> 9 = Unknown	
CLINICAL DATA	Tetanus Toxoid Vaccination History Prior to Tetanus Disease (Exclude Doses Received Since Acute Injury)		Principal Wound Type		Wound Contaminated?					
	<input type="checkbox"/> 0 = Never <input type="checkbox"/> 1 = 1 dose <input type="checkbox"/> 2 = 2 doses <input type="checkbox"/> 3 = 3 doses <input type="checkbox"/> 4 = 4+ doses <input type="checkbox"/> 9 = Unknown		<input type="checkbox"/> 1 = Puncture <input type="checkbox"/> 2 = Stellate Laceration <input type="checkbox"/> 3 = Linear Laceration <input type="checkbox"/> 4 = Crush <input type="checkbox"/> 5 = Abrasion <input type="checkbox"/> 6 = Avulsion		<input type="checkbox"/> 7 = Burn <input type="checkbox"/> 8 = Frostbite <input type="checkbox"/> 9 = Compound Fracture <input type="checkbox"/> 10 = Other (e.g. with cancer) Specify: _____ <input type="checkbox"/> 11 = Surgery		<input type="checkbox"/> 12 = Animal Bite <input type="checkbox"/> 13 = Insect Bite/Sting <input type="checkbox"/> 14 = Dental <input type="checkbox"/> 15 = Tissue Necrosis <input type="checkbox"/> 99 = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	
	Years Since Last Dose		Depth of Wound		Signs of Infection?		Devitalized, Ischemic, or Denervated Tissue Present?			
<input type="text"/> <input type="text"/> 0 - 98 99 = Unknown		<input type="checkbox"/> 1 = 1 cm. or less <input type="checkbox"/> 2 = more than 1 cm. <input type="checkbox"/> 9 = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				

MEDICAL CARE PRIOR TO ONSET	Was Medical Care Obtained For This Acute Injury		Tetanus Toxoid (TT/Td/Tdap) Administered Before Tetanus Onset		If Yes, How Soon After Injury?			
	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> 1 = < 6 Hours <input type="checkbox"/> 2 = 7 - 23 Hours <input type="checkbox"/> 3 = 1 - 4 Days <input type="checkbox"/> 4 = 5 - 9 Days			
	<input type="checkbox"/> 5 = 10 - 14 Days <input type="checkbox"/> 6 = 15+ Days <input type="checkbox"/> 9 = Unknown		Wound Debrided Before Tetanus Onset		If Yes, Debrided How Soon After Injury			
<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> 1 = < 6 Hours <input type="checkbox"/> 2 = 7 - 23 Hours <input type="checkbox"/> 3 = 1 - 4 Days <input type="checkbox"/> 4 = 5 - 9 Days		<input type="checkbox"/> 5 = 10 - 14 Days <input type="checkbox"/> 6 = 15+ Days <input type="checkbox"/> 9 = Unknown		
MEDICAL CARE PRIOR TO ONSET	Associated Condition (if no Acute Injury)		Diabetes?		If Yes, Insulin-Dependent?		Parenteral Drug Abuse?	
	<input type="checkbox"/> 1 = Abscess <input type="checkbox"/> 2 = Ulcer <input type="checkbox"/> 3 = Blister <input type="checkbox"/> 4 = Gangrene <input type="checkbox"/> 5 = Cellulitis		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	
Describe Condition:		Tetanus Immune Globulin (TIG) Prophylaxis Received Before Tetanus Onset		If Yes, TIG Given How Soon After Injury?		Dosage (Units)		
<input type="checkbox"/> 6 = Other Infection <input type="checkbox"/> 7 = Cancer <input type="checkbox"/> 8 = Gingivitis <input type="checkbox"/> 88 = None <input type="checkbox"/> 99 = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> 1 = < 6 Hours <input type="checkbox"/> 2 = 7 - 23 Hours <input type="checkbox"/> 3 = 1 - 4 Days <input type="checkbox"/> 4 = 5 - 9 Days		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 998 999 = Unknown		

CLINICAL COURSE	Type of Tetanus Disease		TIG Therapy Given After Tetanus Onset		If Yes, How Soon After Illness Onset?		Dosage (Units)	
	<input type="checkbox"/> 1 = Generalized <input type="checkbox"/> 2 = Localized <input type="checkbox"/> 3 = Cephalic <input type="checkbox"/> 4 = Unknown		<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<input type="checkbox"/> 1 = < 6 Hours <input type="checkbox"/> 2 = 7 - 23 Hours <input type="checkbox"/> 3 = 1 - 4 Days <input type="checkbox"/> 4 = 5 - 9 Days		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 998 999 = Unknown	
	<input type="checkbox"/> 5 = 10 - 14 Days <input type="checkbox"/> 6 = 15+ Days <input type="checkbox"/> 9 = Unknown		Days Hospitalized		Days In ICU		Days Received Mechanical Ventilation	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 998 999 = Unknown		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 998 999 = Unknown		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 998 999 = Unknown		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 998 999 = Unknown		
Outcome One Month After Onset?				If Died, Date of Death				
<input type="checkbox"/> R = Recovered <input type="checkbox"/> C = Convalescing <input type="checkbox"/> D = Died				<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year				

CS106190 02/09

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NEONATAL (<28 DAYS OLD)	Mother's Age in Years	Mother's Birth Date	Date Mother's Arrival in U.S.	Mother's Tetanus Toxoid Vaccination History PRIOR to Child's Disease (Known Doses Only)	Years Since Mother's Last Dose
	<input type="text"/> 99 = Unknown	<input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="checkbox"/> 0 = Never <input type="checkbox"/> 1 = 1 dose <input type="checkbox"/> 2 = 2 doses <input type="checkbox"/> 3 = 3 doses <input type="checkbox"/> 4 = 4+ doses <input type="checkbox"/> 9 = Unknown	<input type="text"/> 0 - 98 99 = Unknown
	Child's Birthplace	Birth Attendant(s)		Other Birth Attendant(s) (If Not Previously Listed)	
	<input type="checkbox"/> 1 = Hospital <input type="checkbox"/> 2 = Home <input type="checkbox"/> 3 = Other <input type="checkbox"/> 9 = Unknown	<input type="checkbox"/> 1 = Physician <input type="checkbox"/> 2 = Nurse <input type="checkbox"/> 3 = Licensed Midwife <input type="checkbox"/> 4 = Unlicensed Midwife <input type="checkbox"/> 5 = Other <input type="checkbox"/> 9 = Unknown			
	Other Comments?	Reporter's Name		Title	
	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				
	Institution Name		Phone Number		Date Reported
			<input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/> Month Day Year

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

Case Classification*:

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

Notes/Other Information: