TEXAS Health and Human Services | Texas Department of State Health Services

Infectious Disease Prevention Section • Texas Department of State Health Services
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Tetanus Case Track Record

FINAL STATUS:
☐ PROBABLE
☐ RULED OUT/ DROPPED

NBS PATIENT ID#: ________________

Patient's Name: ____
Last First

Address: ____

City: ____________________ County: ____________ Zip: ____________

Region: _______ Phone: ( ) ______________________________

Parent/Guardian: ____

Physician: ______________________ Phone: ( ) ______________

Address: ____

____

Reported By: ______________________________

Agency: ______________________________

Phone: ( ) ______________________________

Date: ____/____/____

Report Given to: ______________________________

Organization: ______________________________

Phone: ( ) ______________________________

Date: ____/____/____

DEMOGRAPHICS: *DATE OF BIRTH:* _____/_____/_____ *AGE:* ________ *SEX:* ☐ Male ☐ Female ☐ Unknown

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown

☐ Other:______________________________ *HISPANIC:* ☐ Yes ☐ No ☐ Unknown

CLINICAL:

☐Hospitalized at: ______________________________ Admitted: _____/_____/_____ Discharged: _____/_____/_____ # Days______

If hospitalized, please obtain medical record and submit with case track

Was this patient in the Intensive Care Unit (ICU)? ☐ Yes ☐ No ☐ Unknown Number of days patient was in ICU:_______ days

Required mechanical ventilation? ☐ Yes ☐ No ☐ Unknown Number of days patient received mechanical ventilation: __________days

Symptom onset date: ____/____/____

Type of Tetanus: ☐ Generalized ☐ Localized ☐ Cephalic

Acute wound identified? ☐ Yes ☐ No ☐ Unknown If YES, date wound occurred: ____/____/____

Work related? ☐Yes ☐ No ☐ Unknown

Environment: ☐ Home ☐Other Indoors ☐ Farm/yard/garden ☐Automobile ☐ 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 ☐ Body Piercing ☐ Burn ☐ Compound Fracture

☐ Crush/Blunt injury ☐ Frostbite ☐ Human Bite ☐ Insect Bite/Sting ☐ Laceration Unspecified

☐ Linear Laceration ☐ Puncture ☐ Stellate Laceration ☐ Surgery ☐ Tattoo

☐ Traumatic Amputation ☐ Unknown ☐ Other:______________________________

Was medical care obtained for the acute wound or injury before tetanus symptom onset? ☐ 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: ☐ Yes ☐ 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, DATE: ____/____/____ ☐ 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.? ☐Yes ☐ No ☐ Unknown If not U.S. born, patient's birth country:___________________________

Occupation: ____

Diabetes? ☐ Yes ☐ No ☐ Unknown If YES, insulin-dependent diabetes? ☐ Yes ☐ No ☐ Unknown

Intravenous drug abuse? ☐ Yes ☐No ☐ Unknown

CDC Objective: 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: ___________________________________ *Jurisdiction:* ____________________ *Phone :(* *)* _________________

Closed in NBS? ☐ *Yes* ☐ *No* *If probable, notification submitted?* ☐ *Yes* ☐ *No*

COMMENTS: