

# 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"/> 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="checkbox"/> R = Recovered <input type="checkbox"/> C = Convalescing <input type="checkbox"/> D = Died		If Died, Date of Death <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	

CS106190 02/09

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<b>NEONATAL (&lt;28 DAYS OLD)</b>	<b>Mother's Age in Years</b>	<b>Mother's Birth Date</b>	<b>Date Mother's Arrival in U.S.</b>	<b>Mother's Tetanus Toxoid Vaccination History PRIOR to Child's Disease</b> (Known Doses Only)	<b>Years Since Mother's Last Dose</b>
	<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
	<b>Child's Birthplace</b>	<b>Birth Attendant(s)</b>		<b>Other Birth Attendant(s)</b> (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			
	<b>Other Comments?</b>	<b>Reporter's Name</b>		<b>Title</b>	
	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				
	<b>Institution Name</b>		<b>Phone Number</b>		<b>Date Reported</b>
			<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: