Anthrax Case Investigation Form

Reset Form

This page is for health department use.
Only a few variables which are mirrored on the following pages are transmitted to CDC.

State
State Case ID
State Patient ID
Medical Record ID

Case Information

First Name | Last Name | Phone

Address | City | ☐ Homeless?

State | State FIPS | State Postal Code | Zip

County | County FIPS

Country of Usual Residence

Sex ☐ Male ☐ Female ☐ Unknown Pregnant ☐ Yes ☐ No ☐ Unknown 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

Contact Type ☐ Parent/Guardian ☐ Other ☐ Spouse/Partner

Contact Name
Contact Phone

Employment Location

Employer Worksite/School Name | Occupation

State | State FIPS

Address | City

County | County FIPS | State Postal Code | Zip

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Collect and send this page to CDC within 24 hours of case identification

Event Code: 10350-Anthrax

State Case ID
State Patient ID
Patient Initials (First, Last)

24 Hour Case Report

Case Classification ☐ Confirmed ☐ Probable ☐ Suspected ☐ Not a Case ☐ Unknown

Classification Determined by ☐ Laboratory Results ☐ Clinical Presentation ☐ Epi Link

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

☐ Inhalation ☐ Gastrointestinal/Oropharayngeal ☐ Cutaneous ☐ Injection ☐ Meningeal

Date of Onset

Date State Notified

Date Local Health Dept. Notified

Time

By ☐ Lab ☐ ICP ☐ Other ☐ HCP ☐ Public Health

County Reporting

Investigator Name	Agency	Phone
HCP Name	Agency	Phone

Demographics (mirrored from page 1)

Sex ☐ Male ☐ Female ☐ Unknown

Pregnant ☐ Yes ☐ No ☐ Unknown

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

State of Residence

State FIPS

County of Residence

County FIPS

Country of Usual Residence

Occupation

State of Employer

State FIPS

County of Employer

County FIPS

Earliest Event Date

Event Date Type

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

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Participated in incident response (e.g., environmental sampling)? ☐ Yes ☐ No ☐ Unknown

Specify exposures encountered in 7 days prior to disease onset.

7 days before onset ← Ask about exposures between these dates → Symptom Onset Date

Exposures

☐ Yes ☐ No ☐ Unknown Exposure to livestock/wild mammals/their body fluids?

Specify animal(s): Describe exposure

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

☐ Yes ☐ No ☐ Unknown Consumed or contact with undercooked or raw meat?

☐ Yes ☐ No ☐ Unknown Exposure to animal products (e.g., untreated animal hair, wool, hides, and animal skin drums)?

Specify product(s) Describe exposure

Dates of exposure

☐ Yes ☐ No ☐ Unknown Gardened or other work with soil?

☐ Yes ☐ No ☐ Unknown If yes, was bone meal fertilizer or similar used?

☐ Yes ☐ No ☐ Unknown Worked in a clinical or microbiological laboratory?

☐ Yes ☐ No ☐ Unknown Exposed to unknown powder?

☐ Yes ☐ No ☐ Unknown Handled suspicious mail?

☐ Yes ☐ No ☐ Unknown Undiagnosed similar illness in friends, family, coworkers, or other contacts?

☐ Yes ☐ No ☐ Unknown Consumed same food/drink as lab-confirmed anthrax case? Specify food/drink

☐ Yes ☐ No ☐ Unknown Exposed to the same environment, animal, or objects as a lab-confirmed anthrax case?

Exposed to what? Where was the exposure?

☐ Yes ☐ No ☐ Unknown Contact with illicit drugs? Name/type

☐ Yes ☐ No ☐ Unknown Received an injection?

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Locations of Exposure(s)

List Locations Routinely Visited During:	
Morning	Noon
Afternoon/Evening	Night

Took public transportation (select all that apply)? ☐ Yes ☐ No ☐ Unknown

☐ Bus ☐ Train ☐ Light Rail ☐ Subway ☐ Ferry ☐ Other, specify:

Specify route (name and/or number)

Specify dates

Attended a large gathering (e.g. concert, sporting event)? ☐ Yes ☐ No ☐ Unknown

Event/Location	Location (Name, Street, City, State, Zip)*	Specify From Date	Specify To Date	Lattitude	Longitude

**Enter all information available; location name, city and state may be sufficient. If a new venue or not a major venue, location name may lower the confidence in the found coordinates. If a good match is not found, you will need to add more address information to get coordinates.*

Attended a place where people congregate (e.g., shopping mall, religious services)? ☐ Yes ☐ No ☐ Unknown

Place Name	Location (Name, Street, City, State, Zip)*	Specify From Date	Specify To Date	Lattitude	Longitude

** Enter all information available; location name, city and state may be sufficient. If a good match is not found, you will need to add more address information to get coordinates.*

Traveled out of the county, state, or country? (enter overflow in Notes section) ☐ Yes ☐ No ☐ Unknown

Destination	Date Departed	Date Returned

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Vaccine and Prophylaxis

Was anthrax vaccine received? ☐ Yes ☐ No ☐ Unknown

If yes, specify what was recieved: ☐ 1- Post-exposure vaccine (1,2, or 3 doses)
☐ 2 - Partial series of pre-exposure vaccine
☐ 3 - Full series of pre-exposure vaccine

Date Last Received Doses received ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5 ☐ Unk

If received a full series of pre-exposure vaccine, is the subject up-to-date on the annual booster vaccine? ☐ Yes ☐ No ☐ Unknown

Received post-exposure antimicrobials? ☐ Yes ☐ No ☐ Unknown

If yes, specify antimicrobial names: ☐ Doxycycline ☐ Ciproflaxin ☐ Amoxicillin ☐ Levfloxacin
☐ Other: Specify

Date received Date ended

Antimicrobials not taken or discontinued? ☐ Yes ☐ No ☐ Unknown

If yes, why? ☐ Low perceived risk ☐ Adverse events ☐ Fear of side effects
☐ Other: Specify

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Signs of Symptoms

Date on Onset Date of Diagnosis

Clinical form at admission: Go to to the 24-hour Report page to change/modify the clinical form(s) of disease.

☐ Inhalation ☐ Gastrointestinal/Oropharyngeal ☐ Cutaneous ☐ Injection ☐ Meningeal

Select ALL symptoms described and signs exhibited by the patient:

General

Fever/Chlls	☐ Yes	☐ No	☐ Unknown
Malaise/Fatigue	☐ Yes	☐ No	☐ Unknown
Nausea/Vomiting	☐ Yes	☐ No	☐ Unknown
Lymphadenopathy	☐ Yes	☐ No	☐ Unknown

Inhalation

Diaphoresis	☐ Yes	☐ No	☐ Unknown
Chest pain	☐ Yes	☐ No	☐ Unknown
Cough	☐ Yes	☐ No	☐ Unknown
Dyspnea	☐ Yes	☐ No	☐ Unknown

Ingestion

Abdominal discomfort	☐ Yes	☐ No	☐ Unknown
Abdominal swelling (i.e., ascites)	☐ Yes	☐ No	☐ Unknown
Diarrhea/Bloody Diarrhea	☐ Yes	☐ No	☐ Unknown
Dysphagia/Sore throat	☐ Yes	☐ No	☐ Unknown

Cutaneous/Injection

Eschar	☐ Yes	☐ No	☐ Unknown
Pustules/Vesicles	☐ Yes	☐ No	☐ Unknown
Pruritus	☐ Yes	☐ No	☐ Unknown
Edema	☐ Yes	☐ No	☐ Unknown
Erythema/Bruising	☐ Yes	☐ No	☐ Unknown
Fascitis	☐ Yes	☐ No	☐ Unknown

Meningeal

Altered mental state	☐ Yes	☐ No	☐ Unknown
Coma	☐ Yes	☐ No	☐ Unknown
Convulsions	☐ Yes	☐ No	☐ Unknown
Severe Headache	☐ Yes	☐ No	☐ Unknown
Photophobia	☐ Yes	☐ No	☐ Unknown

List chronic conditions (e.g., diabetes, hypertension, coronary artery disease, alcohol abuse, hepatitis):

Diet

Vegetarian/Vegan	☐ Yes	☐ No	☐ Unknown
Unknown	☐ Yes	☐ No	☐ Unknown

Smoking Status

Current	☐ Yes	☐ No	☐ Unknown
Never	☐ Yes	☐ No	☐ Unknown
Past	☐ Yes	☐ No	☐ Unknown
Unknown	☐ Yes	☐ No	☐ Unknown

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Diagnostics

Laboratories Performing Diagnostics

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

CDC DASH ID (if tested at CDC)

Select diagnostic studies conducted and findings:

MRI	☐ Yes	☐ No	☐ Unknown	Lumbar puncture	☐ Yes	☐ No	☐ Unknown	Pleural effusion	☐ Yes	☐ No	☐ Unknown
Chest CT	☐ Yes	☐ No	☐ Unknown	Ascites	☐ Yes	☐ No	☐ Unknown	Pericardial effusion	☐ Yes	☐ No	☐ Unknown
CXR	☐ Yes	☐ No	☐ Unknown	Mediastinal Widening	☐ Yes	☐ No	☐ Unknown	Blood CSF	☐ Yes	☐ No	☐ Unknown

Diagnostic Tests Performed

Presumptive tests

Lab # running test (e.g. 1)	Diagnostic Test	Specimen	Collect Date	Collected before antibiotics?	Result	Description
01:	Gram positive rod	☐ Blood/Serum ☐ CSF ☐ Fluid/Effusion ☐ Tissue ☐ Wound ☐ Other		☐ Yes ☐ No ☐ Unk	☐ Positive ☐ Negative ☐ Unknown	
02:	Other CLIA/FDA test:	☐ Blood/Serum ☐ Tissue ☐ CSF ☐ Wound ☐ Fluid/Effusion ☐ Other		☐ Yes ☐ No ☐ Unk	☐ Positive ☐ Negative ☐ Unknown	

Confirmatory Tests

Lab # running test (e.g. 1)	Diagnostic Test	Specimen	Collect Date	Collected before antibiotics?	Result	Description
03:	Culture	☐ Blood/Serum ☐ Tissue ☐ CSF ☐ Wound ☐ Fluid/Effusion ☐ Other		☐ Yes ☐ No ☐ Unk	☐ Positive ☐ Negative ☐ Unknown	
04:	PCR	☐ Blood/Serum ☐ Tissue ☐ CSF ☐ Wound ☐ Fluid/Effusion ☐ Other		☐ Yes ☐ No ☐ Unk	☐ Positive ☐ Negative ☐ Unknown	
05:	Immunostain	☐ Blood/Serum ☐ Tissue ☐ CSF ☐ Wound ☐ Fluid/Effusion ☐ Other		☐ Yes ☐ No ☐ Unk	☐ Positive ☐ Negative ☐ Unknown	
06:	Lethal Factor	☐ Blood/Serum ☐ Tissue ☐ CSF ☐ Wound ☐ Fluid/Effusion ☐ Other		☐ Yes ☐ No ☐ Unk	Collect Date 2 (convalescent)	Titer1 1: Titer 2 1:
07:	Paired Serology (Anti-PA IgG)	☐ Blood/Serum ☐ Tissue ☐ CSF ☐ Wound ☐ Fluid/Effusion ☐ Other		☐ Yes ☐ No ☐ Unk		1: 1:
08:	Other, Specify:	☐ Blood/Serum ☐ Tissue ☐ CSF ☐ Wound ☐ Fluid/Effusion ☐ Other		☐ Yes ☐ No ☐ Unk	☐ Positive ☐ Negative ☐ Unknown	

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Diagnostics Tests Performed

Susceptibility test(s)

Lab #
running test

Check the resistant antimicrobials

☐ Cipro ☐ Clindamycin ☐ Doxycycline
☐ Levofloxacin ☐ Linezolid ☐ Meropenem
☐ Moxifloxacin ☐ Penicillin ☐ Rifampin
☐ Tetracycline

Describe updates

Molecular tests

Lab # running test	Status	Results
MLVA	☐ Not Done ☐ Pending ☐ Unknown	☐ E-test ☐ Rapid ☐ BMD ☐ Other
WGS	☐ Not Done ☐ Pending ☐ Unknown	☐ E-test ☐ Rapid ☐ BMD ☐ Other

Treatment

Hospital ☐ Yes ☐ No ☐ Unknown If yes, date of admission

On vasopressors for any length of time? ☐ Yes ☐ No ☐ Unknown
On mechanical ventilation for any length of time? ☐ Yes ☐ No ☐ Unknown

Transferred ☐ Yes ☐ No ☐ Unknown To Facility [Name]

Final Treatment Place Phone

Address City State

Antimicrobials given for illness? ☐ Yes ☐ No ☐ Unknown

If yes, enter the antimicrobials used for treatment of anthrax:

Antimicrobial name	Other, specify	Start date	End date	No. days	Route
					☐ p.o. ☐ i.v. ☐ Unknown
					☐ p.o. ☐ i.v. ☐ Unknown
					☐ p.o. ☐ i.v. ☐ Unknown

AIG given... ☐ Yes ☐ No ☐ Unknown Date
Raxibacurnab given? ☐ Yes ☐ No ☐ Unknown Date

Other treatments

Outcome

Clinical Outcome

☐ Outpatient, treated ☐ Still hospitalized ☐ Discharged ☐ Not treated
☐ Died ☐ Other ☐ Unknown

Date of Discharge
Date of Death

Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

Facility City

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☐ Updated Case Report

Submit Case Data to CDC

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Note

CS300660

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Print Form

Save Form

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