



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF SURVEILLANCE

TETANUS REPORT

CASE NO.

PATIENT	NAME (LAST, FIRST, M.I.)			COUNTY
	ADDRESS	CITY	STATE	ZIP CODE
Reporting Physician Nurse/Hosp/ Clinic	NAME			TELEPHONE
	ADDRESS	CITY		ZIP CODE

DEMOGRAPHICS

BIRTHDATE (MONTH/DAY/YEAR)	RACE	ETHNICITY
SEX	<input type="checkbox"/> NATIVE AMER./ALASKAN NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> OTHER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> HISPANIC <input type="checkbox"/> NOT HISPANIC <input type="checkbox"/> UNKNOWN
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		

HISTORY

HISTORY OF MILITARY/NATIONAL GUARD SERVICE	YEAR OF TETANUS ONSET	YEAR OF ENTRY INTO MILITARY OR NATIONAL GUARD	OCCUPATION
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN			

VACCINATION HISTORY

TETANUS TOXOID (TT) HISTORY PRIOR TO TETANUS DISEASE (EXCLUDE DOSES RECEIVED SINCE ACUTE INJURY)	YEARS SINCE LAST DOSE
<input type="checkbox"/> NEVER <input type="checkbox"/> 2 DOSES <input type="checkbox"/> 4+ DOSES <input type="checkbox"/> 1 DOSE <input type="checkbox"/> 3 DOSES <input type="checkbox"/> UNKNOWN	

CLINICAL DATA

ACUTE WOUND IDENTIFIED?	DATE WOUND OCCURRED (MONTH/DAY/YEAR)	WORK RELATED
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
PRINCIPAL ANATOMIC SITE	CIRCUMSTANCES (DESCRIBE IN DETAIL)	
<input type="checkbox"/> HEAD <input type="checkbox"/> UPPER EXTREMITY <input type="checkbox"/> UNSPECIFIED <input type="checkbox"/> TRUNK <input type="checkbox"/> LOWER EXTREMITY		
ENVIRONMENT	WOUND CONTAMINATED?	
<input type="checkbox"/> HOME <input type="checkbox"/> FARM/YARD <input type="checkbox"/> OTHER OUTDOORS <input type="checkbox"/> OTHER INDOORS <input type="checkbox"/> AUTOMOBILE <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
PRINCIPAL WOUND TYPE	SIGNS OF INFECTION?	
<input type="checkbox"/> PUNCTURE <input type="checkbox"/> LINEAR LACERATION <input type="checkbox"/> AVULSION <input type="checkbox"/> COMPOUND FRACTURE <input type="checkbox"/> STELLATE LACERATION <input type="checkbox"/> CRUSH <input type="checkbox"/> BURN <input type="checkbox"/> OTHER <input type="checkbox"/> ABRASION <input type="checkbox"/> FROSTBITE <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
DEPTH OF WOUND	DEVITALIZED, ISCHEMIC OR DENERVATED TISSUE PRESENT?	
<input type="checkbox"/> 1 CM. OR LESS <input type="checkbox"/> MORE THAN 1 CM. <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	

MEDICAL CARE PRIOR TO ILLNESS ONSET

WAS MEDICAL CARE OBTAINED FOR THIS ACUTE INJURY?	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
TETANUS TOXOID (TT) ADMINISTERED BEFORE TETANUS ONSET?	IF YES, TT GIVEN HOW SOON AFTER INJURY?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> < 6 HRS <input type="checkbox"/> 1-4 DAYS <input type="checkbox"/> 10-14 DAYS <input type="checkbox"/> UNKNOWN <input type="checkbox"/> 7-23 HRS <input type="checkbox"/> 5-9 DAYS <input type="checkbox"/> 15+ DAYS
WOUND DEBRIDED BEFORE TETANUS ONSET?	IF YES, DEBRIDED HOW SOON AFTER INJURY?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> < 6 HRS <input type="checkbox"/> 1-4 DAYS <input type="checkbox"/> 10-14 DAYS <input type="checkbox"/> UNKNOWN <input type="checkbox"/> 7-23 HRS <input type="checkbox"/> 5-9 DAYS <input type="checkbox"/> 15+ DAYS
TETANUS IMMUNE GLOBULIN (TIG) PROPHYLAXIS RECEIVED BEFORE TETANUS OFFSET	IF YES, TIG GIVEN HOW SOON AFTER INJURY?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN DOSAGE (IN UNITS) _____	<input type="checkbox"/> < 6 HRS <input type="checkbox"/> 1-4 DAYS <input type="checkbox"/> 10-14 DAYS <input type="checkbox"/> UNKNOWN <input type="checkbox"/> 7-23 HRS <input type="checkbox"/> 5-9 DAYS <input type="checkbox"/> 15+ DAYS
ASSOCIATED CONDITION (IF NO ACUTE INJURY)	DESCRIBE CONDITION
<input type="checkbox"/> ABSCESS <input type="checkbox"/> BLISTER <input type="checkbox"/> CELLULITIS <input type="checkbox"/> NONE <input type="checkbox"/> ULCER <input type="checkbox"/> GANGRENE <input type="checkbox"/> OTHER INFECTION	
DIABETES?	IF YES, INSULIN-DEPENDENT?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
PARENTERAL DRUG ABUSE?	DESCRIBE
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	

