Anthrax Investigation form

Case ID |_____|

I. Reporting

Date of reporting: _____/_____/_____ Health facility: .....

Reported name: ..... Phone: .....

Treating physician: ..... Phone: .....

**

II. Patient identification

Patient full name: ..... Address, Caza: .....

Date of birth: _____/_____/_____ City/locality: .....

Sex: ☐ Male ☐ Female Detailed address: .....

Nationality: .....

Phone number: .....

**

III. Occupation

Occupation: ..... Institution name: .....

Activity: ☐ Active ☐ Unemployed Occupation phone: .....

Anthrax vaccination ☐ Yes, date: ☐ No Institution address: .....

Date last dose: _____/_____/_____

**

IV. Clinical presentation

Date of onset of 1st symptoms: _____/_____/_____

General	Gastrointestinal or Oropharyngeal	Cutaneous or Injection	Inhalation	Meningeal
☐ Fever	☐ Abdominal pain/tenderness	☐ Pruritis	☐ Chest pain	☐ Headache
☐ Malaise/fatigue	☐ Abdominal swelling	☐ Erythema	☐ Cough	☐ Photophobia
☐ Anorexia	☐ Vomiting	☐ Edema	☐ Dyspnea	☐ Neck pain/stiffness
☐ Hypoxia	☐ Diarrhea (not bloody)	☐ Vesicles	☐ Hemoptysis	☐ Convulsions
☐ Cyanosis	☐ Bloody diarrhea	☐ Eschar	☐ Acute respiratory distress	☐ Altered mental status
☐ Other:	☐ Neck swelling	☐ Cellulitis	☐ Abnormal chest x-ray	☐ Coma
	☐ Pharyngitis	☐ Fasciitis	☐ Other:	☐ Other:
	☐ Oropharyngeal lesions	☐ Lymphadenopathy		
	☐ Other:	☐ Lymphangitis		
		☐ Other:		

**

V. Laboratory testing

Specimen type	Nb	Date of collection	Date of shipment	Test	Laboratory	Result
Blood						
CSF						
Vesicular fluid						
Swab						
Peritoneal fluid						
Ascitic fluid						
Other:						

**

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VI. Case management

a) Health facility

Name	Treating MD	Admission	Admission date	ICU	Date discharge

b) Antibiotics

Name	Date started	Date ended	Posology	Notes

**

VII. Cutaneous / injection form

In the past 14 days prior to disease onset, did the patient:

- Work with or around livestock/wild mammals or their body fluids? ☐ Yes ☐ No ☐ Unknown
  If yes, specify: Date of exposure: _____/_____/_____
  Location of exposure:
  Animal type:
- Had any contact with animal skins, furs, hair, or bone products? ☐ Yes ☐ No ☐ Unknown
  If yes, specify: Date of exposure: _____/_____/_____
  Location of exposure:
  Product type:
- Garden or work with soil? ☐ Yes ☐ No ☐ Unknown
  If yes, specify: Date of exposure: _____/_____/_____
  Location of exposure:
- Work in a clinical or microbiological laboratory? ☐ Yes ☐ No ☐ Unknown
  If yes, specify: Date of exposure: _____/_____/_____
  Location of exposure:
- Receive an injection: ☐ Yes ☐ No ☐ Unknown
  If yes, specify: Date of injection: _____/_____/_____
  Drug type: ☐ Medicinal ☐ Illicit
  Drug name:
  Injection site:
  Conducted by:

**

VIII. Gastro-intestinal / oropharyngeal form

In the past 7 days prior to disease onset, did the patient:

- Consume or was exposed to undercooked or raw meat? ☐ Yes ☐ No ☐ Unknown
  If yes, specify: Date of exposure: _____/_____/_____
  Location of exposure:
  Consumed items:
  Source:
- Consumed same food/drink as lab-confirmed anthrax case? ☐ Yes ☐ No ☐ Unknown
  If yes, specify: Date of exposure: _____/_____/_____
  Location:
  Consumed items:
  Source:

**

Anthrax Investigation form

Case ID |_____|

IX. Inhalation form

In the past 60 days prior to disease onset, did the patient:

▪ Receive unusual letters or packages?	☐ Yes If yes, specify:	☐ No ☐ Unknown Date of exposure: Location of exposure: Country source:	_____/_____/_____
▪ Open mails or packages for others:	☐ Yes If yes, specify:	☐ No ☐ Unknown Date of exposure: Location of exposure: Details:	_____/_____/_____
▪ Had contact with unusual powders, dusts or aerosols?	☐ Yes If yes, specify:	☐ No ☐ Unknown Date of exposure: Location of exposure: Details:	_____/_____/_____

**

X. Exposure

In the past 6 weeks prior to disease onset, did the patient:

▪ Attend large gatherings or special events?	☐ Yes If yes, specify:	☐ No ☐ Unknown Date of event: Location of event:	_____/_____/_____
▪ Travel outside the country?	☐ Yes If yes, specify:	☐ No ☐ Unknown Date of travel: Country: Date of return:	_____/_____/_____ _____/_____/_____
▪ Get in contact with undiagnosed similar illness in friends, family, coworkers, or other contacts?	☐ Yes If yes, specify:	☐ No ☐ Unknown Date of contact: Contact's name: Contact's location: Contact's phone:	_____/_____/_____

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XI. Outcome and classification

Dates	Status (alive, recovered, death)	Classification	Notes (date of death if death)

**

XII. Environmental investigation

Dates	Partner	Inspection/Sampling	Results

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XIII. Investigator

Form filled by: (name and signature) Date: _____/_____/_____