

# ANTHRAX INVESTIGATION FORM

**STOP: PRIOR TO CREATING THIS INVESTIGATION, YOU MUST NOTIFY & CONSULT WITH CENTRAL OFFICE  
(800) 338-8374 (24-HOUR COVERAGE)**

## BASIC DEMOGRAPHIC DATA

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ years months Current Sex: Female Male Unknown

Is the patient deceased? No Unknown Yes Date of Death: \_\_\_/\_\_\_/\_\_\_\_

Street Address 1: \_\_\_\_\_ Street Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Work Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_\_

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

## INVESTIGATION SUMMARY

Investigation Start Date: \_\_\_/\_\_\_/\_\_\_\_ Investigation Status: Open Closed Investigator: \_\_\_\_\_

## REPORTING SOURCE

Date of Report: \_\_\_/\_\_\_/\_\_\_\_ Reporting Source: \_\_\_\_\_

## CLINICAL

Physician's Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_\_

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name: \_\_\_\_\_

Admission Date: \_\_\_/\_\_\_/\_\_\_\_ Discharge Date: \_\_\_/\_\_\_/\_\_\_\_ Duration of Stay \_\_\_\_\_ day(s)

Diagnosis Date: \_\_\_/\_\_\_/\_\_\_\_ Illness Onset Date: \_\_\_/\_\_\_/\_\_\_\_ Illness End Date: \_\_\_/\_\_\_/\_\_\_\_

Age at Onset: \_\_\_\_\_ days hours minutes months unknown weeks years

Did the patient die from this illness? No Unknown Yes Date of Death: \_\_\_/\_\_\_/\_\_\_\_

## EPIDEMIOLOGIC

Is this patient associated with a day care facility? No Unknown Yes Is this patient a food handler? No Unknown Yes

Is this case part of an outbreak? No Unknown Yes If yes, outbreak name: \_\_\_\_\_

Case Status: Confirmed Not a Case Probable Suspect Unknown MMWR Week: \_\_\_\_\_ MMWR Year: \_\_\_\_\_

## ADMINISTRATIVE

General Comments: \_\_\_\_\_

## PHA4 SUPERVISOR REVIEW

Date Due: \_\_\_/\_\_\_/\_\_\_\_ Investigation ready for supervisor review: Reviewed (Complete) Reviewed (Incomplete)

Date investigation ready for supervisor review: \_\_\_/\_\_\_/\_\_\_\_ Reviewed (Not a case) Yes

Review comments (completed by supervisor): \_\_\_\_\_

**CONTACT ATTEMPTS**

Physician Contact Date(s):

1<sup>st</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_ 2<sup>nd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_ 3<sup>rd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_

Patient Contact Date(s):

1<sup>st</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM PM 2<sup>nd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM PM3<sup>rd</sup> Attempt: \_\_\_/\_\_\_/\_\_\_\_ Time: \_\_\_\_\_ AM PM

Regular Letter Mailed: \_\_\_/\_\_\_/\_\_\_\_ Certified Letter Mailed: \_\_\_/\_\_\_/\_\_\_\_

Was clinical information obtained from the physician or patient? Yes No**SIGNS AND SYMPTOMS**Did the patient have a fever ( $\geq 100.4^{\circ}\text{F}$ )? No Unknown YesWas the patient septic? No Unknown Yes**Cutaneous Anthrax:**Eschar, location: \_\_\_\_\_ Lymphadenopathy Malaise Papule that became vesicular**Inhalation Anthrax:**Acute respiratory distress Dyspnea (short of breath) Mediastinal widening Shock  
Cyanosis Hypoxia Pleural effusion Viral respiratory-like illness**Intestinal Anthrax:**Abdominal swelling Bloody Diarrhea Nausea Vomiting  
Anorexia Hematemesis (bloody vomit) Severe abdominal pain**Oropharyngeal Anthrax:**Cervical adenopathy Edema Painless oral mucosal lesion Pharyngitis**Meningeal Anthrax:**Coma Convulsions Meningeal signs (e.g., meningitis)**EXPOSURES**

What is the patient's primary occupation? \_\_\_\_\_ Name and location of employer: \_\_\_\_\_

In the 7 days prior to onset of symptoms did patient have exposure to or contact with any of the following?

Livestock: No Unknown Yes Date: \_\_\_/\_\_\_/\_\_\_\_ Location: \_\_\_\_\_Animal skins, fur, or hair: No Unknown Yes Date: \_\_\_/\_\_\_/\_\_\_\_ Location: \_\_\_\_\_