Oregon Anthrax Case Investigation Form

Please send **Page 1** of this form to OPHD within **24 hours** of case identification.
Send **Pages 2-4** of this form within **1 week** of case identification, or when feasible.

If a case dies within 1 week of onset, please notify OPHD within 24 hours of death

CASE IDENTIFICATION

First Name _____ Last Name _____ Phone _____
Home Address _____ Homeless _____
City _____ County _____ State _____ Zip _____
Contact Name _____ Phone _____
Employer/Worksite/School Name _____
Address _____ City _____ State _____ Zip _____

----Remove the above case identification section before submission to CDC-----

Collect and send to OPHD within 24 hours of case identification

[State Use Only]

Outbreak No. _____ **State of Residence** _____ _____ **State Case ID** _____

Case Classification (see Case Definition below) □ Confirmed □ Presumptive □ Suspect
State Notified Date _____
Local Health Department Notified Date _____ time _____ by _____
Reporting County _____

Sex _____ **Pregnant** _____ **Birth date** _____ **Age** _____ ☐ month ☐ years
Race _____ **Ethnicity** _____
Country of usual residence _____ **County of residence** _____
Date of Onset _____ **Occupation** _____
Date of Diagnosis _____

Suspected clinical form at admission ***(select all that apply)*** **:**
___ Cutaneous __ Inhalation __ Meningeal ___ Gastrointestinal/ Oropharyngeal ___ Injection

Investigator Name _____ **Investigator Phone** _____
Treating HCP _____ **HCP Phone** _____
Earliest Event Date _____ **Event Date Type** _____

Suspect: An illness suggestive of one of the known anthrax clinical forms. No definitive, presumptive, or suggestive laboratory evidence of B. anthracis, or epidemiological evidence relating it to anthrax.
Probable: Clinically compatible illness not meeting confirmed definition, but with either: Epidemiological link to documented environmental exposure, evidence of B. anthracis DNA by LRN-validated PCR from a normally sterile site or from a lesion from other tissue, positive test on serum Quick ELISA Anthrax PA kit; detection of Lethal Factor in serum by mass spectrometry, or positive RedLine Alert test on culture from clinical specimens.
Confirmed: Compatible illness with either: Culture of *B. anthracis* by LRN from clinical specimen, demonstration of *B. anthracis* antigens in tissue by immunohistochemical staining using both cell wall and capsule MAbs, 4-fold rise in protective antigen antibody, or documented anthrax environmental exposure AND evidence of *B. anthracis* DNA in specimens from a normally sterile site or lesion from affected tissue.
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EXPOSURES

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

Documented Exposure Event: _____

___ Participated in incident response (e.g., environmental sampling)?

Specify exposures encountered prior to disease onset. Exposure window depends on the Clinical Forms.

14 days prior for Cutaneous & Injection
60 days prior for Inhalation & Meningeal
7 days prior for GI / Oropharyngeal
(use longest incubation window when case exhibits >1 Clinical Form)

Earliest possible exposure date	*Ask about exposures* between these dates (enter dates in boxes)	Symptom Onset Date

___ Exposure to livestock/ wild mammals/ their body fluids?
Specify animal(s) _____
Describe contact _____
Animal(s) disposition? _____
___ Date(s) of exposure *(mm/dd)* _____ - _____
___ Consumed or exposure to undercooked or raw meat?
___ Exposure to animal products (e.g., untreated animal hair, wool, hides, and animal skin drums)?
Specify product(s) _____
Describe exposure _____
Date(s) of exposure *(mm/dd)* _____ - _____
___ Gardened or other work with soil?
___ If yes, was bone meal fertilizer or similar used?

___ Worked in a clinical or microbiological laboratory?
___ Exposed to unknown powder?
___ Handled suspicious mail?
___ Undiagnosed similar illness in friends, family, coworkers, or other contacts?
___ Consumed same food/drink as lab-confirmed anthrax case?
Specify food / drink _____
___ Exposed to the same environment, animal, or objects as a lab-confirmed anthrax case?
Exposed to what? _____
Where was the exposure? _____
___ Contact with illicit drugs? _____
Name/Type _____
___ Received an injection?

LOCATION OF EXPOSURE

List locations routinely visited during: morning: _____ noon: _____ afternoon / evening: _____ night: _____

___ Took public transportation?
If yes, select all that apply: ___ Bus ___ Train ___ Light rail ___ Subway ___ Ferry ___ Other *(Specify:)* _____
Specify location(s) _____ Specify date(s) *(mm/dd)* _____ to _____

___ Attended a large gathering *(e.g., concert, sporting event)?* Specify event(s) _____
Specify location(s) _____ Specify date(s) *(mm/dd)* _____, _____, _____

___ Attended a place where people congregate *(e.g., shopping mall, religious services)?*
Specify location(s) _____ Specify date(s) *(mm/dd)* _____, _____, _____

___ Traveled out of county, state, or country? *(enter overflow travel in Notes section)*

Destination 1	_____	Date departed	_____	Date returned	_____
Destination 2	_____	Date departed	_____	Date returned	_____
Destination 3	_____	Date departed	_____	Date returned	_____

VACCINE & PROPHYLAXIS

___ Was anthrax vaccine administered? If yes, specify what was administered: _____
Date last received (mm/yy) _____ Doses Received _____
___ Received **Post-Exposure** Antimicrobials Date received (mm/dd) _____ Date ended (mm/dd) _____
Antimicrobials _____
Antimicrobials not taken or discontinued? If yes, why?

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CLINICAL FORM & PRESENTATION

Select ALL symptoms described and signs exhibited by the patient

General
- ___ Fever
- ___ Anorexia
- ___ Malaise/ fatigue
- ___ Cyanosis
- ___ Hypoxia

Gastrointestinal or Oropharyngeal
- ___ Abdominal pain/tenderness
- ___ Abdominal swelling
- ___ Diarrhea / vomit
- ___ Bloody?
- ___ Oropharyngeal lesions
- ___ Pharyngitis
- ___ Neck swelling

Meningeal
- ___ Altered mental status
- ___ Coma
- ___ Convulsions
- ___ Headache
- ___ Neck pain/stiffness
- ___ Photophobia

Cutaneous or Injection
- ___ Cellulitis
- ___ Edema
- ___ Erythema
- ___ Eschar
- ___ Fasciitis
- ___ Lymphadenopathy
- ___ Lymphangitis
- ___ Pruritus
- ___ Vesicles

Inhalation
- ___ Acute respiratory distress
- ___ Chest pain
- ___ Cough
- ___ Dyspnea
- ___ Hemoptysis

List chronic conditions: _____

DIAGNOSTIC & LABORATORY RESULTS

Laboratories Conducting Testing — **List tests done by each laboratory**

Lab Name 1 _____ City _____ State _____ _____

Lab Name 2 _____ City _____ State _____ _____

Lab Name 3 _____ City _____ State _____ _____

Radiographic and Imaging Studies

___ MRI ___ Chest CT ___ CXR ___ Ascites ___ Mediastinal widening ___ Pleural Effusion

Test	Specimen	Date Collected	Collected before given antibiotics?	Positive or Titer
Culture 1	_____	_____	___	___
Culture 2	_____	_____	___	___
Culture 3	_____	_____	___	___
PCR 1	_____	_____	___	___
PCR 2	_____	_____	___	___
PCR 3	_____	_____	___	___
Lateral flow assay	_____	_____	___	___
Immunostain	_____	_____	___	___
LF mass spectrometry	_____	_____	___	___
Quick ELISA anti-PA	Acute	_____	___	1: _____
Anti-PA Iggy ELISA	Acute	_____	___	1: _____
Other: _____	_____	_____	___	___

Date of Laboratory Diagnosis _____

	Date collected	Titer
Convalescent	_____	1: _____
Convalescent	_____	1: _____

TREATMENT & OUTCOME

Hospitalized? ____Yes ____No Facility _____ If yes, Admission Date_____

Admitted to ICU for any length of time? _____ On mechanical ventilation for any length of time? _____

Transferred? ____Yes ____No To Facility [Name] _____

Final treatment place _____ Address _____

City _____ State _____ Phone _____

Antimicrobials given for illness? _____

If yes, enter the antimicrobials used for treatment of anthrax

	Start Date	End Date	# days	Antimicrobial	Route
1	_____	_____	___	_____	_____
2	_____	_____	___	_____	_____
3	_____	_____	___	_____	_____
4	_____	_____	___	_____	_____
5	_____	_____	___	_____	_____
6	_____	_____	___	_____	_____
7	_____	_____	___	_____	_____
8	_____	_____	___	_____	_____

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TREATMENT & OUTCOME, *continued*

AIG given? _____ Date _____ Raxibacumab given? _____ Date _____

Other treatments given _____

_____

Clinical outcome _____ Discharge date _____ Date of Death _____

If patient died, was an autopsy performed? _____ Facility _____ City _____

NOTES

State Case ID _____