Anthrax Case Report Form General Instructions

Instructions

Please complete as much of the form as possible. The instructions below explain each variable. If you have questions, please contact Bacterial Special Pathogens Branch at (404) 639-1711 or bspb@cdc.gov.

Send the completed form with all personal identifiers removed to CDC either by:

Email: bspb@cdc.gov

Fax: (404) 929-1590

DCIPHER: contact bspb@cdc.gov for more information

NOTE: All Sections: record date as MM/DD/YYYY

Reporting Information	Description
Date of Notification	Date case was first reported to jurisdiction.
State Case ID	Unique Identifier given by the state health department.
NNDSS Case ID	If different from State Case ID, provide the Case Identifier transmitted in NNDSS.
Reporter Name, Phone Number, and Email	Contact information for person reporting the case to CDC.
Reporting Jurisdiction	State, territory, or jurisdiction reporting to CDC.

Demographic Information	Description
Sex	Genetic sex of patient.
Pregnant	Pregnancy status at the onset of current illness.
Date of Birth	Patient's date of birth, if known.
Age	Age of patient at time of diagnosis.
Residence	State, territory, county, and zip code of residence.
Race and Ethnicity	Race and ethnicity of patient as noted in the chart or reported by physician or infection control personnel (ICP). Multiple boxes may be checked. Do not make assumptions based on name or native language. If race or ethnicity is unknown, please check "Unknown."
Country of Birth	Indicate original country of birth, including U.S. born. If unknown, please enter "Unknown."
Country of Residence	Indicate country of residence, if not U.S. If unknown, please enter "Unknown."
Occupation	List the patient's current occupation.
Employer	Specify the name of the patient's employer for the above occupation. If unknown, please enter "Unknown."
Occupation location	Identify the state, territory, or jurisdiction of the patient's employment.

Case Information	Description
Case Classification	Indicate the patient's case classification based on the anthrax case definition. Confirmed and Probable cases must be reported to CDC following the notification criteria outlined in the CSTE position statement (24-ID-01).
Case Determination	Indicate method by which case classification was determined.
Infection Route	Indicate suspected primary route of infection.
Onset Date	Indicate date of clinical symptoms onset. If exact date unknown, supply best approximation.
Meningitis	Indicate if meningitis was present.
Signs/Symptoms/Conditions	Select patient-described symptoms or clinician-identified conditions associated with illness.

Treatment and Outcome	Description
Hospitalization	Indicate whether the patient was admitted to a hospital for this illness. Enter admission and discharge dates, if applicable.
Outcome	Indicate the outcome of the patient following this illness. If the patient died, list the date and location of death, and indicate if an autopsy was performed.
Treatment	Select all antibiotic(s) the patient was prescribed and list the start date for each. If prescribed antibiotic is not listed, list the name and start date, if known.
Antitoxin	If antitoxin was administered, specify the name of the antitoxin, date of request, and date of each dose administered.
Vaccine	Identify if the patient has ever received anthrax vaccine. If yes, indicate if the vaccine was administered pre-exposure or post-exposure. If pre-exposure enter date of last dose. If post-exposure identify the name of the vaccine and enter dates for each dose received.
Antibiotic PEP	If antibiotic prophylaxis was prescribed, identify all antibiotics prescribed and date the patient started taking each medication. If prescribed antibiotic is not listed, list the name of the antibiotic prescribed and the date the patient started the medication.

Test & Specimen Information *(Please complete a new test section for each laboratory test performed)*	Description
Test Type	Indicate the type of laboratory test performed. If other, specify the test.
Performing Laboratory	Indicate the laboratory that performed the test.
Specimen	Identify the type of specimen collected for testing, and date specimen collected.
Result	Indicate any quantitative, qualitative or other results acquired from the test above. If determine by the test, report what organism (e.g., *B. anthracis*) was identified in the sample.

Supplemental	Description
Outbreak	Indicate whether the case was part of a known outbreak. If yes, proceed to Module 1: Outbreak/Known Exposure. If no, proceed to Module 2: Unknown Exposure.
Animals and Animal Products	Indicate whether the patient was exposed to animals (e.g., cows) and/or animal products (e.g., hides) in the 14 days prior to illness. If yes, proceed to Module 3: Animal Exposure.
Metal Work	Indicate whether the patient worked with metal (e.g., welding) in the 14 days prior to illness. If yes, proceed to Module 4: Metal Exposure.
Medical Chart Abstraction	Proceed to Module 5: Medical Chart Abstraction if the patient's medical chart is available and/or if the patient has a pre-existing condition, uses tobacco or e-cigarettes, or was hospitalized.
Antimicrobial Susceptibility	Indicate whether antimicrobial susceptibility tests were performed on the sample. If yes, proceed to Module 6: Antimicrobial Susceptibility.

Module 1: Outbreak/Known Exposure	Description
Outbreak Information	Indicate the name of the outbreak, the earliest known date of the start of the outbreak, and location of the outbreak.
Patient Encounter with Outbreak	Indicate how the patient may have been exposed and the location of exposure.

Module 2: Unknown Exposure	Description
Soil Exposure	Indicate whether the patient was exposed to soil in the 14 days prior to illness and method of exposure.
Laboratory Exposure	Indicate whether the patient was exposed to a clinical, microbiological, or research laboratory in the 14 days prior to illness and the specific location of exposure.
Undiagnosed Contact	Indicate whether the patient encountered undiagnosed people with similar illness in the 14 days prior to illness.
Unknown White Powder	Indicate whether the patient was exposed to an unknown white powder in the 14 days prior to illness.
Suspicious Mail	Indicate whether the patient was exposed to suspicious mail in the 14 days prior to illness.
Public Transit Use	Indicate whether the patient used public transit in the 14 days prior to illness. For each route used in the 14 days prior to illness, indicate the type of transportation, the route number, and the dates and times of exposure.
Locations Visited	Indicate what locations the patient visited in the 14 days prior to illness, as well as the dates and times of these visits.
Travel	Indicate whether the patient traveled out of the state or country in the 14 days prior to illness. For any travel, indicate the destination and the dates of travel.

Module 3: Animal Exposure	Description
Animal Exposure	Indicate if the patient had contact with any animals or their bodily fluids in the 14 days prior to illness. Then, indicate what kind of animal the patient was exposed to, who owned the animal (business, the patient/another individual, etc), the date and location of exposure, and the vaccination status of the animal, if known.
Animal Exposure Activities	Indicate what activities the patient participated in (e.g., herding, cleaning enclosures, slaughtering) when exposed to the animal, as well as how many animals were encountered during these activities.
Animal Testing and Outcomes	Indicate if the animal was confirmed to have anthrax with laboratory testing, when the test was performed, and what kind of test was used. Additionally, note what symptoms and clinical signs were exhibited by the sick/dead animals.
Animal Product Exposure	Indicate if the patient was exposed to any animal products in the 14 days prior to illness. Then, report what kind of material was used (e.g. wool, bones), the specific product encountered (e.g. drum, hairbrush), how this product was acquired, and where the product was encountered.

Module 4: Metal Exposure	Description
Metal Exposure	Indicate whether the patient was exposed to metal in the 14 days prior to illness. Then, report the date of exposure, how the patient worked with the metal (e.g., welding), the location of exposure, the type of metal, and the tools used during metal work.
Metal Work Conditions	Indicate whether the patient worked with metal outside, along with any exposure to possible occupational hazards.
Personal Protective Equipment Use	Indicate whether the patient used any sort of personal protective equipment during their metal working activities, as well as what personal protective equipment was used.
Metal Workspace Exposure	Indicate if the patient was exposed to metal work by products via inhalation or ingestion. Specifically, report any sweeping, ventilation/air flow, eating, or handwashing in the workspace.

Module 5: Medical Chart Abstraction	Description
Pre-Existing Medical Conditions	Indicate whether the patient has any pre-existing medical conditions. Specify the conditions, as needed.
Substance Use	Indicate whether the patient smokes or drinks. For each substance they use, indicate how much they consume.
Hospital Records	Indicate what treatments and/or procedures the patient has undergone in a hospital setting, as well as any pertinent findings from procedures.

Module 6: Antimicrobial Susceptibility	Description
Antimicrobial Susceptibility Testing	Indicate whether the patient's sample has been tested for antimicrobial susceptibility. Specify which antibiotics were tested, what testing method was used, and any pertinent findings from these tests.

GENERAL ANTHRAX CRF

This form is intended for all cases, including outbreaks.
NOTE: Enter all dates as MM/DD/YYYY

REPORTING INFORMATION

Date Reported: _____ Reporting Jurisdiction: _____ State Case ID: _____

NNDSS Case ID: _____ Reporter Name: _____ Reporter Phone Number: _____

Reporter Email: _____

DEMOGRAPHIC INFORMATION

Sex: ○ Male ○ Female ○ Refused ○ Unknown DOB: _____ Age: _____ ○ Years ○ Months ○ Days

Pregnant: ○ Yes ○ No ○ Unknown RESIDENCE: State: _____ County: _____ Zip Code: _____

Country of Usual Residence: _____ Country of Birth: _____

Race:
☐ American Indian/Alaskan Native
☐ Asian
☐ White
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Unknown
☐ Other: _____

Ethnicity:
○ Hispanic
○ Non-Hispanic
○ Unknown

Occupation: _____ Other: _____

Employer name: _____ Occupation state or territory: _____

CASE INFORMATION

Case Classification:
○ Confirmed ○ Not a case
○ Probable ○ Unknown
○ Suspect

Classification determined by *(select all that apply)*:
☐ Lab Result ☐ N/A
☐ Epi link ☐ Unknown
☐ Clinical Presentation

Suspected primary route of infection *(select all that apply)*:
☐ Cutaneous ☐ Injection
☐ Inhalation ☐ Unknown
☐ Ingestion

Date of symptom onset: _____

Was meningitis present? ○ Yes ○ No ○ Unknown

Signs/Symptoms/Conditions *(select all that apply)*:

☐ Fever/chills	☐ Cough	☐ Pustule	☐ Multiple lesions	☐ Coma
☐ Malaise/fatigue	☐ Abdominal pain	☐ Pruritus	☐ Fasciitis	☐ Convulsions
☐ Nausea/vomiting	☐ Abdominal swelling	☐ Edema	☐ Meningeal signs	☐ Severe headache
☐ Lymphadenopathy	☐ Diarrhea	☐ Erythema	☐ Altered mental status	☐ Photophobia
☐ Diaphoresis	☐ Dysphagia/sore throat	☐ Bullae	☐ Confusion	
☐ Chest pain	☐ Eschar	☐ Ecchymosis	☐ Obtundation	

☐ Other:

TREATMENT AND OUTCOME

Was the patient hospitalized? ○ Yes ○ No ○ Unknown Admit date: _____ Discharge date: _____

Clinical outcome
○ Still hospitalized
○ Still sick (outpatient)
○ Recovered
○ Long-term disability
○ Died
○ Unknown

Date of death: _____

Where did the death occur?
○ Home
○ ED
○ Hospital
○ Nursing Facility
○ Hospice
○ Other
○ Unknown

Specify other: _____

Was an autopsy performed?
○ Yes ○ No ○ Unknown

Reporting Jurisdiction: _____ NNDSS Case ID: _____

Were antibiotics prescribed or administered to this patient for treatment of this illness? ○ Yes ○ No ○ Unknown

Antibiotics prescribed *(select all that apply)*

☐ Meropenem	Start date: _____	☐ Penicillin	Start date: _____
☐ Imipenem/Cilastatin	Start date: _____	☐ Ampicillin	Start date: _____
☐ Doxycycline	Start date: _____	☐ Ampicillin/Sulbactam	Start date: _____
☐ Minocycline	Start date: _____	☐ Other: _____	Start date: _____
☐ Ciprofloxacin	Start date: _____	☐ Other: _____	Start date: _____
☐ Levofloxacin	Start date: _____	☐ Unknown	Start date: _____

Was antitoxin administered to the patient? ○ Yes ○ No ○ Unknown

Specify antitoxin: ○ AIG ○ Obiltoxaximab ○ Raxibacumab ○ Unknown

Date last dose received: _____

Did the patient ever receive anthrax vaccine? ○ Yes ○ No ○ Unknown

If Yes, ○ Pre-Exposure ○ Post-Exposure ○ Unknown

If Pre-Exposure, Date last dose received: _____

If Post-Exposure, was the treatment: ○ AVA ○ AVA Adjuvanted ○ Unknown

Date dose 1: _____

Date dose 2: _____

Date dose 3: _____

Were antibiotics prescribed or administered to this patient for prevention of illness (i.e. prophylaxis)? ○ Yes ○ No ○ Unknown

Antibiotic prophylaxis prescribed *(select all that apply)*:

☐ Doxycycline	Start date: _____	☐ Ampicillin	Start date: _____
☐ Minocycline	Start date: _____	☐ Ampicillin/sulbactam	Start date: _____
☐ Ciprofloxacin	Start date: _____	☐ Other: _____	Start date: _____
☐ Levofloxacin	Start date: _____	☐ Other: _____	Start date: _____
☐ Clindamycin	Start date: _____	☐ Unknown	Start date: _____
☐ Penicillin	Start date: _____		

TEST AND SPECIMEN INFORMATION – *Please complete a new section for each test performed*

1st Test & Specimen

Test Type: ○ PCR ○ Serology ○ Immunostaining ○ WGS ○ Culture ○ Lethal factor ○ MLVA ○ Other: _____

Performing lab: ○ CDC ○ Other LRN ○ Unknown ○ SPHL ○ Commercial Lab ○ Other

Performing laboratory name: _____

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Swab ○ Isolate ○ Tissue ○ Pleural/ascites ○ Other

Specify other: _____ Specify tissue type: _____ Collection date: _____

Qualitative result: ○ Positive ○ Negative ○ Indeterminate ○ Borderline ○ Other: _____

Quantitative result: Result: _____ Other result (wgs/mlva): _____

Organism: ○ *Bacillus anthracis* ○ *Bacillus cereus* ○ *Bacillus spp* ○ Other

Specify other: _____

Result Date: _____

Specimen collected before antibiotic treatment? ○ Yes ○ No ○ Unknown

Reporting Jurisdiction: _____ NNDSS Case ID: _____

2nd Test & Specimen

Test Type: ○ PCR ○ Serology ○ Immunostaining ○ WGS ○ Culture ○ Lethal factor ○ MLVA ○ Other: _____

Performing lab: ○ CDC ○ Other LRN ○ Unknown ○ SPHL ○ Commercial Lab ○ Other — **Performing laboratory name:** _____

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Swab ○ Isolate ○ Tissue ○ Pleural/ascites ○ Other — **Specify other:** _____ **Specify tissue type:** _____ **Collection date:** _____

Qualitative result: ○ Positive ○ Negative ○ Indeterminate ○ Borderline ○ Other: _____

Quantitative result: **Result:** _____ **Other result (wgs/mlva):** _____

Organism: ○ *Bacillus anthracis* ○ *Bacillus spp* ○ *Bacillus cereus* ○ Other — **Specify other:** _____

Result Date: _____ **Specimen collected before antibiotic treatment?** ○ Yes ○ No ○ Unknown

3rd Test & Specimen

Test Type: ○ PCR ○ Serology ○ Immunostaining ○ WGS ○ Culture ○ Lethal factor ○ MLVA ○ Other: _____

Performing lab: ○ CDC ○ Other LRN ○ Unknown ○ SPHL ○ Commercial Lab ○ Other — **Performing laboratory name:** _____

Specimen type: ○ Whole blood ○ Cerebrospinal fluid ○ Serum ○ Swab ○ Isolate ○ Tissue ○ Pleural/ascites ○ Other — **Specify other:** _____ **Specify tissue type:** _____ **Collection date:** _____

Qualitative result: ○ Positive ○ Negative ○ Indeterminate ○ Borderline ○ Other: _____

Quantitative result: **Result:** _____ **Other result (wgs/mlva):** _____

Organism: ○ *Bacillus anthracis* ○ *Bacillus spp* ○ *Bacillus cereus* ○ Other — **Specify other:** _____

Result Date: _____ **Specimen collected before antibiotic treatment?** ○ Yes ○ No ○ Unknown

Notes:

Reporting Jurisdiction: _____ NNDSS Case ID: _____

Supplement Data Questions

Please complete ALL question in this section to determine all modules that need to be filled out before proceeding.

Is this case part of a known outbreak? *Select yes if the source of exposure has been identified.*

○ Yes ○ No ○ Unknown **If *Yes*, proceed to Module 1 (below)**
If *No*, proceed to Module 2

Did the patient have contact with any animals or animal products (hides, bones, wool, meat) 14 days prior to illness onset?

○ Yes ○ No ○ Unknown **If *Yes*,** proceed to Module 3

Did the patient weld or work with metals in the 14 days prior to illness onset?

○ Yes ○ No ○ Unknown **If *Yes*,** proceed to Module 4

Was additional social and medical history collected about the patient?

○ Yes ○ No ○ Unknown **If *Yes*,** proceed to Module 5

Was antimicrobial susceptibility testing performed?

○ Yes ○ No ○ Unknown **If *Yes*,** proceed to Module 6

MODULE 1: OUTBREAK / KNOWN EXPOSURE

This module is intended for cases that are associated with a known anthrax event or outbreak where the source has already been identified. If the case is NOT associated with a known event /outbreak or the exposure has not been identified, please complete module 2 (unknown exposure) instead.

Outbreak Name: _____ Earliest event date: _____

State/Territory: _____ Country: _____

Did the patient participate in incident response (e.g., environmental sampling)?

○ Yes
○ No
○ Unknown

If ***Yes***, specify type of activity: _____

Did the patient have the same exposure as a lab confirmed case?

○ Yes
○ No
○ Unknown

If ***Yes***, Specify exposure: _____ Specify contact: _____

Country of exposure: _____ State or territory of exposure (if U.S.): _____

MODULE 2: UNKNOWN EXPOSURE

All questions in this section are pertaining to the 14 days prior to symptom onset.

Did the patient have contact with or exposure to soil? ○ Yes ○ No ○ Unknown

Specify work with soil:

_____

Worked in a clinical, microbiological or animal research laboratory? ○ Yes ○ No ○ Unknown

If yes, specify lab:

_____

Contact with undiagnosed people with similar illness? ○ Yes ○ No ○ Unknown

Exposed to unknown white powder? ○ Yes ○ No ○ Unknown

Handled suspicious mail? ○ Yes ○ No ○ Unknown

Did the patient use public transit? ○ Yes ○ No ○ Unknown

List all known public transit usage below

Type of Transportation *(e.g., bus, train, ferry, light rail, subway, rideshare)*	**Name of Transportation Service**	**Route name or number**	**From (Date)**	**To (Date)**	**Time**

List locations visited (routine, events, group gatherings etc.)

Location Name	**Address (street address, state, city, zip code)**	**From (Date)**	**To (Date)**	**Time**

Did the patient travel out of the state or country? ○ Yes ○ No ○ Unknown

If Yes,

U.S. State: _____ or Country: _____ Dates of Travel: _____ to _____

U.S. State: _____ or Country: _____ Dates of Travel: _____ to _____

U.S. State: _____ or Country: _____ Dates of Travel: _____ to _____

Did the patient use non-injectable drugs that were not prescribed to them by a doctor or purchased over the counter?

○ Yes ○ No ○ Unknown Specify drug: _____

Did the patient use injectable drugs that were not prescribed to them by a doctor or purchased over the counter?

○ Yes ○ No ○ Unknown Specify drug: _____

Last known drug usage date: _____

MODULE 3: ANIMAL EXPOSURE

All questions in this section are pertaining to the 14 days prior to symptom onset.

Animal Exposure

Identify the type of animal the patient had contact with and the type of contact *(Select all that apply)*

Contact Type	Cattle	Sheep	Goats	Deer	Horse/ Equines/ Equids	Dogs	Other Animal, Specify: _____	Unknown Animal
Herding	☐	☐	☐	☐	☐	☐	☐	☐
Birthing	☐	☐	☐	☐	☐	☐	☐	☐
Collection of Animal Products (Milking/Shearing)	☐	☐	☐	☐	☐	☐	☐	☐
Cleaning Enclosure or Tools for Animal Care	☐	☐	☐	☐	☐	☐	☐	☐
Hunting	☐	☐	☐	☐	☐	☐	☐	☐
Skinning, Slaughtering, Butchering	☐	☐	☐	☐	☐	☐	☐	☐
Carcass Movement/Disposal	☐	☐	☐	☐	☐	☐	☐	☐
Other, Specify: _____	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐

Animal ownership *(Select all that apply)*

Ownership Type	Cattle	Sheep	Goats	Deer	Horse/ Equines/ Equids	Dogs	Other Animal, Specify: _____	Unknown Animal
Commercial/Domestic	☐	☐	☐	☐	☐	☐	☐	☐
Wild	☐	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐	☐

First known date of exposure: _____ Last known date of exposure: _____

Specify location where animal contact took place:

Country, if not U.S.: _____ State, if U.S: _____

Were the animals vaccinated against anthrax? ○ Yes ○ No ○ Unknown If yes, last date of exposure: _____

What vaccination practices were used with these animals?

○ Ring vaccination (vaccinating when at risk)
○ Annual vaccination (vaccinated yearly regardless of risk)
○ Other: _____
○ Unknown

If the patient had contact with sick/dead animals, indicate type of animal:

☐ Cattle ☐ Goats ☐ Horse/equines/equids ☐ Unknown
☐ Sheep ☐ Deer ☐ Dogs ☐ Other, specify: _____

About how many sick/dead animals did the patient come into contact with?

○ 1-5
○ More than 5

Were the animals confirmed to have anthrax with laboratory testing? ○ Yes ○ No ○ Unknown

Test Date: _____ Specify Test(s): _____

If sick or dead, what clinical signs and symptoms did the animals have?

Animal Product Exposure

NOTE: This also includes products that contain animal products, such as, but not limited to, bone meal fertilizer, drums made with animal hides, brushes with bristles made from animal hair, etc.

What animal product did the patient handle? *Select all that apply.* See Note from above.

Animal Product	Cattle	Sheep	Goats	Deer	Horse/ Equines/ Equids	Other Animal, Specify: _____	Unknown Animal
Hide	☐	☐	☐	☐	☐	☐	☐
Wool/Hair	☐	☐	☐	☐	☐	☐	☐
Raw or Undercooked Meat	☐	☐	☐	☐	☐	☐	☐
Bones	☐	☐	☐	☐	☐	☐	☐
Other, Specify: _____	☐	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐	☐

Specify the product (e.g., drum, hide, hairbrush, etc.)? _____

In what country was the product produced? _____

How was the animal product acquired?

- ○ Purchased in person domestically (within U.S.)
- ○ Obtained internationally
- ○ Purchased online
- ○ Received as gift
- ○ Taken directly from slaughtered animal
- ○ Unknown
- ○ Other, specify: _____

Where was the patient exposed to this product?

- ○ Manufacturing/processing setting
- ○ Agricultural setting
- ○ Home
- ○ Work
- ○ Unknown
- ○ Other, specify: _____

MODULE 4: METAL EXPOSURE

All questions in this section are pertaining to the 14 days prior to symptom onset.

Recent Metal Exposure

Last known exposure date: _____

In what context did the patient work with metal?

- ○ Commercially/for job with company
- ○ Recreationally/as a hobby
- ○ Privately/as an independent contractor
- ○ None
- ○ Unknown
- ○ Other, specify: _____

Location of metal exposure.

- ○ Manufacturing/processing setting
- ○ Agricultural setting
- ○ Home
- ○ Work
- ○ Unknown
- ○ Other, specify: _____

Did the patient have exposure to any of the following metals? *Select all that apply.*

- ☐ Mild steel/low carbon steel/iron
- ☐ Stainless steel
- ☐ Iconel (nickel-chromium alloys)
- ☐ Aluminum
- ☐ Chromium/chromium alloys
- ☐ Nickel/nickel alloys
- ☐ Titanium
- ☐ Unknown
- ☐ Other, specify: _____

What type/s of metal-working processes had the patient used? *Select all that apply.*

- ☐ MIG
- ☐ TIG
- ☐ Stick
- ☐ Laser beam
- ☐ Plasma arc
- ☐ Electron beam
- ☐ Gas welding
- ☐ Brazing
- ☐ Grinding
- ☐ Flame cutting
- ☐ Other
- ☐ Unknown

Did the patient perform any metal working activities outdoors?

○ Yes ○ No ○ Unknown

If *Yes*, specify: _____

Was the patient exposed to any of the following during metal work? *Select all that apply.*

- ☐ Solvents
- ☐ Wood dust
- ☐ Smoke
- ☐ Exhaust fumes
- ☐ Soil
- ☐ None
- ☐ Unknown

Did the patient have contact to soil unrelated to metal-working?

○ Yes ○ No ○ Unknown

Metal Exposure Safety

What personal protective equipment was used by the patient for metal working? *Select all that apply.*

- ☐ Welding helmet/shield
- ☐ N95
- ☐ N99
- ☐ N100
- ☐ R95
- ☐ R99
- ☐ R100
- ☐ P95
- ☐ P99
- ☐ P100
- ☐ Other respirator: _____
- ☐ Cloth mask/face mask
- ☐ Goggles
- ☐ Fire/Flame-resistant clothing
- ☐ Earmuffs/plugs
- ☐ Boots
- ☐ Gloves
- ☐ Unknown
- ☐ Other: _____

Was compressed air used during patient's metal work?

○ Yes ○ No ○ Unknown

Did the patient perform dry sweeping as part of clean-up activities?

○ Yes ○ No ○ Unknown

Are any welding materials stored outside?

○ Yes ○ No ○ Unknown **If yes, list materials:** _____

What kind of air ventilation was used when metal working? *Select all that apply.*

- ☐ Work outside
- ☐ Work inside with fume hood
- ☐ Work inside with fan
- ☐ Work inside with other form of ventilation
- ☐ None
- ☐ Unknown
- ☐ Specify other air ventilation: _____

How often did the patient change clothes and footwear after finishing metal work?

○ Sometimes ○ Always ○ Never ○ Unknown

How often did the patient wash their hands before eating or drinking during metal work?

○ Sometimes ○ Always ○ Never ○ Unknown

How often did the patient wash their hands after finishing metal work?

○ Sometimes ○ Always ○ Never ○ Unknown

How often did the patient eat in the same area they worked with metal?

○ Sometimes ○ Always ○ Never ○ Unknown

MODULE 5: PAST MEDICAL AND SOCIAL HISTORY

Medical History

Does/did the patient have pre-existing medical conditions? ○ Yes ○ No ○ Unknown

If yes, select all that apply:

- ☐ Diabetes Melitus
- ☐ Hypertension
- ☐ Severe Obesity (BMI ≥ 40)
- ☐ Cardiovascular Disease
- ☐ Chronic Liver Disease
- ☐ Chronic Lung Disease (Asthma/ Emphysema/COPD)
- ☐ Immunosuppressive Condition
- ☐ Autoimmune Condition
- ☐ Neurologic/Neurodevelopmental/ Intellectual Disability
- ☐ Psychological/Psychiatric Condition
- ☐ Other Chronic Condition, Underlying Condition, or Risk Behavior

Specify Neurologic/Neurodevelopmental/Intellectual Disability: _____

Specify Psychological/Psychiatric Condition: _____

Specify Other Chronic or Underlying Condition/Risk Behavior: _____

What is the patient's current smoking status (cigarettes, vapes, etc)? ○ Current ○ Past ○ Never ○ Unknown

If current or past:

How many packs of cigarettes per day? _____ For how many years? _____

In the past 30 days, how often did the patient drink alcoholic beverages?

○ Never ○ Monthly ○ Weekly ○ Daily

On the days the patient drank, about how many alcoholic beverages did the patient drink on average? _____

Hospitalized Patients

Was the patient admitted to the ICU? ○ Yes ○ No ○ Unknown

Was the patient mechanically ventilated? ○ Yes ○ No ○ Unknown

Was the patient on vasopressors? ○ Yes ○ No ○ Unknown

Which of the following procedures did the patient undergo?

○ Thoracentesis ○ Pericardiocentesis ○ None
○ Paracentesis ○ Lumbar Puncture

If lumbar puncture was performed, was blood present in the CSF?

○ Yes ○ No ○ Unknown

Indicate all hospital imaging and findings for the patient. Complete a new block for each imaging procedure and finding.

Hospital Imaging 1	Imaging Findings 1
○ MRI ○ Ultrasound ○ CT ○ Chest Xray ○ Other	○ Ascites ○ Mediastinal Widening ○ Pleural Effusion ○ Pulmonary Infiltrates ○ Pericardial Effusion ○ Intracranial Hemorrhage ○ Specify other: _____

Hospital Imaging 2	Imaging Findings 2
○ MRI ○ Ultrasound ○ CT ○ Chest Xray ○ Other	○ Ascites ○ Mediastinal Widening ○ Pleural Effusion ○ Pulmonary Infiltrates ○ Pericardial Effusion ○ Intracranial Hemorrhage ○ Specify other: _____

Hospital Imaging 3	Imaging Findings 3
○ MRI ○ Ultrasound ○ CT ○ Chest Xray ○ Other	○ Ascites ○ Mediastinal Widening ○ Pleural Effusion ○ Pulmonary Infiltrates ○ Pericardial Effusion ○ Intracranial Hemorrhage ○ Specify other: _____

MODULE 6: ANTIMICROBIAL SUSCEPTIBILITY

Please complete a new section for each test performed

Antimicrobial susceptibility tested

○ Amoxicillin ○ Doxycycline ○ Meropenem ○ Vancomycin
○ Ciprofloxacin ○ Imipenem ○ Moxifloxacin ○ Other
○ Clarithromycin ○ Levofloxacin ○ Penicillin
○ Clindamycin ○ Linezolid ○ Tetracycline

Specify other antimicrobial tested: _____

Antimicrobial susceptibility test type. *Select all that apply.*

☐ E-test ☐ BMD ☐ Rapid ☐ Other Specify other: _____

Result/Interpretation MIC (ug/ml): _____ ○ Susceptible ○ Resistant ○ Not susceptible ○ No CLSI breakpoint

Antimicrobial susceptibility tested

○ Amoxicillin ○ Doxycycline ○ Meropenem ○ Vancomycin
○ Ciprofloxacin ○ Imipenem ○ Moxifloxacin ○ Other
○ Clarithromycin ○ Levofloxacin ○ Penicillin
○ Clindamycin ○ Linezolid ○ Tetracycline

Specify other antimicrobial tested: _____

Antimicrobial susceptibility test type. *Select all that apply.*

☐ E-test ☐ BMD ☐ Rapid ☐ Other Specify other: _____

Result/Interpretation MIC (ug/ml): _____ ○ Susceptible ○ Resistant ○ Not susceptible ○ No CLSI breakpoint

Reporting Jurisdiction: _____ NNDSS Case ID: _____

Antimicrobial susceptibility tested

○ Amoxicillin	○ Doxycycline	○ Meropenem	○ Vancomycin
○ Ciprofloxacin	○ Imipenem	○ Moxifloxacin	○ Other
○ Clarithromycin	○ Levofloxacin	○ Penicillin	
○ Clindamycin	○ Linezolid	○ Tetracycline	

Specify other antimicrobial tested: _____

Antimicrobial susceptibility test type. *Select all that apply.*

☐ E-test ☐ BMD ☐ Rapid ☐ Other **Specify other:** _____

Result/Interpretation **MIC (ug/ml):** _____ ○ Susceptible ○ Resistant ○ Not susceptible ○ No CLSI breakpoint

Antimicrobial susceptibility tested

○ Amoxicillin	○ Doxycycline	○ Meropenem	○ Vancomycin
○ Ciprofloxacin	○ Imipenem	○ Moxifloxacin	○ Other
○ Clarithromycin	○ Levofloxacin	○ Penicillin	
○ Clindamycin	○ Linezolid	○ Tetracycline	

Specify other antimicrobial tested: _____

Antimicrobial susceptibility test type. *Select all that apply.*

☐ E-test ☐ BMD ☐ Rapid ☐ Other **Specify other:** _____

Result/Interpretation **MIC (ug/ml):** _____ ○ Susceptible ○ Resistant ○ Not susceptible ○ No CLSI breakpoint

RESET