ANTHRAX INVESTIGATION WORKSHEET

MR #: _____ **CDRSS #:** _____

Demographics

Patient Last Name	First Name	DOB:	Phone number
		____ / ____ / ____	
Address		**City**	**Municipality**

Ethnicity
- ◯ Hispanic
- ◯ Non-Hispanic
- ◯ Unknown

Race
◯ White ◯ Black ◯ Asian ◯ Pacific Islander ◯ American Indian or Alaskan Native ◯ Unknown

Occupation

Industry / work setting

Clinical Status

Was the patient hospitalized because of this illness?
◯ Yes ◯ No ◯ Unknown

Hospital: _____

Admitted: ____ / ____ / ____ Discharged: ____ / ____ / ____

Did the patient die because of this illness?
◯ Yes ◯ No ◯ Unknown

If yes, specify date of death: ____ / ____ / ____

Treating physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Lab contact information

Name of lab: _____

Point of contact at lab: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Select a response for each sign or symptom below and include onset/resolution dates

Sign/Symptom	Response	Onset Date	Resolution Date
Abdominal discomfort	◯ Yes ◯ No ◯ Unk.		
Abdominal swelling (ascites)	◯ Yes ◯ No ◯ Unk.		
Abnormal lung sounds	◯ Yes ◯ No ◯ Unk.		
Body aches	◯ Yes ◯ No ◯ Unk.		
Altered mental status	◯ Yes ◯ No ◯ Unk.		
Bruising	◯ Yes ◯ No ◯ Unk.		
Chest pain	◯ Yes ◯ No ◯ Unk.		
Chills	◯ Yes ◯ No ◯ Unk.		
Coagulopathy	◯ Yes ◯ No ◯ Unk.		
Coma	◯ Yes ◯ No ◯ Unk.		
Convulsions	◯ Yes ◯ No ◯ Unk.		
Cough	◯ Yes ◯ No ◯ Unk.		
Diaphoresis (excessive sweating)	◯ Yes ◯ No ◯ Unk.		
Diarrhea	◯ Yes ◯ No ◯ Unk.		
Dyspnea	◯ Yes ◯ No ◯ Unk.		
Edema (swelling)	◯ Yes ◯ No ◯ Unk.		
Erythema	◯ Yes ◯ No ◯ Unk.		
Fasciitis	◯ Yes ◯ No ◯ Unk.		
Fatigue	◯ Yes ◯ No ◯ Unk.		
Fever Specify:_____	◯ Yes ◯ No ◯ Unk.		
Hemoptysis	◯ Yes ◯ No ◯ Unk.		
Hypotension	◯ Yes ◯ No ◯ Unk.		
Leukocytosis	◯ Yes ◯ No ◯ Unk.		

Malaise (discomfort)	○ Yes ○ No ○ Unk.		
Nausea	○ Yes ○ No ○ Unk.		
Papule	○ Yes ○ No ○ Unk.		
Photophobia	○ Yes ○ No ○ Unk.		
Pneumonia	○ Yes ○ No ○ Unk.		
Pruritus (itching)	○ Yes ○ No ○ Unk.		
Pustules	○ Yes ○ No ○ Unk.		
Seizure	○ Yes ○ No ○ Unk.		
Severe headache	○ Yes ○ No ○ Unk.		
Sore throat	○ Yes ○ No ○ Unk.		
Tachycardia (rapid heart rate)	○ Yes ○ No ○ Unk.		
Tachypnea	○ Yes ○ No ○ Unk.		
Vesicles	○ Yes ○ No ○ Unk.		
Vomiting	○ Yes ○ No ○ Unk.		

Additional signs:		**Description (e.g. location, size, tenderness, erythema, eschar etc.):**
Abscess deep under the skin	○ Yes ○ No ○ Unk.	
Acute mediastinitis	○ Yes ○ No ○ Unk.	

Additional signs:		**Description (e.g. location, size, tenderness, erythema, eschar etc.):**
Depressed black eschar	○ Yes ○ No ○ Unk.	
Meningoencephalitis	○ Yes ○ No ○ Unk.	
Pleural effusion	○ Yes ○ No ○ Unk.	
Skin lesions	○ Yes ○ No ○ Unk.	
Rash	○ Yes ○ No ○ Unk.	
Lymphadenopathy	○ Yes ○ No ○ Unk.	

Other signs/symptoms (specify):

Risk Factors

In the 2 months prior to illness onset, did the patient have an exposure to livestock or wild mammals or their body fluids?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient consume or have contact with undercooked or raw meat?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, was the patient exposed to animal products?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient garden or have other exposure to soil or bone meal fertilizer?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient work in a clinical or microbiology laboratory?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient have an exposure to an unknown powder?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient handle suspicious mail?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient have contact with illicit drugs?	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient travel outside of NJ? Specify location: _____	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient travel outside of the US? Specify location: _____	○ Yes ○ No ○ Unk.
In the 2 months prior to illness onset, did the patient have contact with metal fumes or mineral dusts through welding or metal work?	○ Yes ○ No ○ Unk.

Describe any YES responses:

Diagnostic Testing

Was a chest x-ray preformed? ◯ Yes ◯ No ◯ Unk. Date: _____ Findings:	Was a culture preformed? ◯ Yes ◯ No ◯ Unk. Collection Date:_____ Findings within 24 hours:

Provide any additional information on pertinent diagnostic testing:

Treatment - List all antibiotics received and dates of initiation and discontinuation

Antibiotic	Dosage	Start date	End date

Additional Case Notes