



Arizona Department of Health Services

Bureau of Epidemiology & Disease Control
Office of Infectious Disease Services
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Arizona Anthrax Case Report

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Gender: [] Male [] Female [] Unknown

Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

Telephone: _____ Telephone: _____

Race: [] White [] Black [] Asian/Pacific Islander [] Native American [] Other [] Unknown

Ethnicity: [] Hispanic [] Not Hispanic [] Unknown

[] Pregnant Due date: _____

[] Underlying conditions/ Immunodeficiency: _____

Worksites, schools, daycare center: _____

Occupation: _____

Employer: _____

SOURCE OF REPORT

[] Laboratory [] Physician [] Infection Control Practitioner [] Hospital [] Other

Other: _____

PHYSICIAN

Name: _____ Hospital: _____

Address: _____

Telephone: _____ Email: _____

ILLNESS

Onset date: _____ Diagnosis date: _____

Attending physician: _____ Telephone: _____

Hospital: _____ Telephone: _____

Date of admission: _____ Date of discharge: _____

System: Gastrointestinal Inhalation Cutaneous lesions- site: _____

<http://www.bt.cdc.gov/agent/anthrax/anthrax-hcp-factsheet.asp>

TREATMENT

Antibiotic treatment: _____ 1st dose: _____ Last dose: _____

Outcome: Recovered Died In-house Date of death: _____

Medical record number: _____

SYMPTOMS

Generalized	Cutaneous	Pulmonary	Gastrointestinal
<input type="checkbox"/> Fever	<input type="checkbox"/> Pre-existing wound	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Nausea
<input type="checkbox"/> Chills	<input type="checkbox"/> Edema	<input type="checkbox"/> Cough	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Headache	<input type="checkbox"/> Eschar	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Myalgia	<input type="checkbox"/> Reg. lymphadenopathy		<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Fatigue			

Other: _____

LABORATORY TESTING

Test	Specimen	Collected	Results	Laboratory
<input type="checkbox"/> Culture				
<input type="checkbox"/> PCR				
<input type="checkbox"/> Serologic				
<input type="checkbox"/> IHC				
<input type="checkbox"/> <i>B. anthracis</i> is confirmed <input type="checkbox"/> Bioterrorism is suspected				

EXPOSURE

Possible sources of infection within exposure period of 8 weeks before onset of illness

Patient works in livestock industry

Patient is exposed to: Cattle Sheep Goats Other _____

Animal(s) are alive Animal(s) are dead Animal(s) are ill

Condition of animals: _____

Veterinary diagnosis: _____

Location of exposure: _____

Facility Owner: _____

Date(s) of exposure: _____

Patient was exposed to animal products: Hides Hair Wool Undercooked meat

Other: _____

Date(s) of exposure: _____

Location of exposure: _____

Description: _____

Travel within 8 weeks prior to onset of symptoms

Location / dates: _____

Patient's occupation involves handling mail or Patient handled suspicious powder/substance

Location / dates: _____

OUTBREAK

There is similar illness within the household or with close contacts

Name	Relationship	Onset	Description

CASE DEFINITION

http://www.cdc.gov/ncphi/diss/nndss/casedef/antrax_current_1.htm

Resource website: <http://www.bt.cdc.gov/agent/anthrax/surveillance/>

INTERVIEW

Date of interview: _____ Interviewer Name: _____

Agency: _____

County notified State notified CDC notified Other notified: _____

NOTES
