SURVEILLANCE OF TETANUS – CASE INVESTIGATION FORM

EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH

The MOH should do the investigation personally. Necessary data should be obtained from the hospital by reference to the BHT/Physician or from the diagnosis card. Early investigation and return are essential.

Week ending of notification ☐☐ ☐☐ ☐☐ (d d m m y y)	Serial No: ☐☐☐☐	Please write the Serial No given in the Infectious Disease Register (ID Register) in the MOH Office

A. PARTICULARS OF PATIENT *(Please tick (✓) the appropriate box where applicable)*

1. Name of patient (BLOCK LETTERS) .....

2. Residential address: .....

3. Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

4. Age	5. Sex	6. Ethnic group	7. Occupation	8. DPDHS Division (district)	9. MOH area
☐☐/☐☐ (y y / m m)	☐ 1. male ☐ 2. female ☐ 3. not known	☐ 1. Sinhalese ☐ 2. Tamil ☐ 3. Moor ☐ 4. others ☐ 5. not known	.....	.....	.....
			FOR OFFICE USE ONLY		
			☐☐	☐☐	☐☐

B. PRESENT ILLNESS/OUTCOME

10. Date of onset of symptoms: ☐☐ ☐☐ ☐☐ (d d m m y y)

11. Where did the patient first seek medical advice?
- ☐ 1. government hospital
- ☐ 2. private hospital
- ☐ 3. private practitioner
- ☐ 4. Ayurvedic institution (public/private)
- ☐ 5. other (specify) .....

12. Was patient admitted to hospital?
- ☐ 1. yes → to Q. 13
- ☐ 2. no
- ☐ 3. not known

} skip to Q. 21

13. If yes, date of admission: ☐☐ ☐☐ ☐☐ (d d m m y y)

14. Name of hospital: .....

15. Ward: .....

16. BHT no: .....

17. Date of discharge/transfer or death: ☐☐ ☐☐ ☐☐ (d d m m y y)

18. If transferred, name of hospital .....

19. Was patient transferred from some other hospital?
☐ 1. yes ☐ 2. no

20. If "yes", where was the patient transferred from? .....

21. Outcome of the case
- ☐ 1. cured ☐ 3. transferred
- ☐ 2. died ☐ 4. not known

C. NATURE OF INJURY (ONLY IN TETANUS CASES)

22. Date of injury: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

23. **Situation**	24. **Type of injury**	25. **Location of wound**
☐ 1. home accident	☐ 1. puncture wound	☐ 1. head
☐ 2. occupational accident	☐ 2. lacerated wound	☐ 2. face and neck
☐ 3. road traffic accident	☐ 3. abrasion	☐ 3. chest
☐ 4. surgical procedure	☐ 4. contusion	☐ 4. upper limbs
☐ 5. child birth	☐ 5. surgical procedure	☐ 5. abdomen region
☐ 6. abortion	☐ 6. burns	☐ 6. pelvis
☐ 7. others (specify)	☐ 7. other (specify)	☐ 7. lower limbs
☐ 8. not known	☐ 8. not known	☐ 8. other (specify) .....
		☐ 9. not known

D. CLINICAL DATA

Case definition: acute onset of hypertonia and/or painful muscular contractions (usually of the muscles of the jaw and neck) and generalized muscle spasms without other apparent medical cause.

26. **Symptoms and signs**
- ☐ 1. stiffness of jaw
- ☐ 2. difficulty in swallowing
- ☐ 3. stiffness in neck/arms/leg
- ☐ 4. restlessness
- ☐ 5. trismus
- ☐ 6. risus sardonicus
- ☐ 7. opisthotonos
- ☐ 8. convulsions
- ☐ 9. other (specify):.....

For office use only
Compatible with the case definition:
- ☐ 1. Yes
- ☐ 2. No

E. POST EXPOSURE TREATMENT

27. Has the patient sought medical care after the injury?
- ☐ 1. yes
- ☐ 2. no
- ☐ 3. not known

28.Type of care
- ☐ 1. Western
- ☐ 2. Ayurveda
- ☐ 3. others (specify) .....
- ☐ 4. not known

29. If 'Western' treatment received:

Treatment:	Date and no. of doses given			Not given	Not known
	Dose 1	Dose 2	Dose 3		
post exposure tetanus toxoid	☐☐/☐☐ d d / m m	☐☐/☐☐ d d / m m	☐☐/☐☐ d d / m m		
anti tetanus serum (ATS) / tetanus immunoglobulin (TIG)	☐☐/☐☐ ..... IU	☐☐/☐☐ ..... IU	☐☐/☐☐ ..... IU		

30. If not given, reasons: .....

.....

F. TETANUS VACCINATION STATUS

31. Provide the vaccination status at the time of **disease onset**:

Dose	Date of immunization*	Place of immunization**	Batch number
☐ T1 or ☐ DPT 1			
☐ T2 or ☐ DPT 2			
☐ T3 or ☐ DPT 3			
☐ T4 or ☐ DPT 4			
☐ T5 or ☐ DT			
☐ T6 or ☐ aTd			

*If the date is not known but the particular dose has been given, mark (✓) in the relevant box
** MOH office/ Govt. hospital/ private dispensary/ private hosp./ other/ not known

G. ONLY IN NEO-NATAL TETANUS CASES

Case definition: any neonate with a normal ability to suck and cry during the first two days of life, who, between 3 and 28 days of age could not suck normally and became stiff and/or had convulsions

32. Name of the mother (block letters)

.....

33. Age of the baby: ☐☐ days

34. Parity: ☐☐

35. Date of delivery

☐☐ ☐☐ ☐☐
d d m m y y

36. Place of delivery
- ☐ 1. govt. hosp
- ☐ 2. private hosp
- ☐ 3. home
- ☐ 4. other (specify) .....

37. Delivered by:
- ☐ 1. doctor
- ☐ 2. nurse
- ☐ 3. institutional midwife
- ☐ 4. field midwife
- ☐ 5. untrained birth attendant
- ☐ 6. other (specify) .....
- ☐ 7. not known

38. Symptoms and signs of the baby
- ☐ 1. normal sucking and crying for first 3 days of life
- ☐ 2. inability to suck between 3 – 28 days
- ☐ 3. stiffness
- ☐ 4. convulsions
- ☐ 5. other (specify) .....

39. Vaccination status of the mother:

Dose	Date of immunization* (dd/mm/yy)	Place of immunization**	Batch number
TT 1			
TT 2			
TT 3			
TT 4			
TT 5			

*If the date is not known but the particular dose has been given, mark (✓) in the relevant box
**MOH clinic/ govt. hospital/ private dispensary/ private hosp/ other/ not known

40. Remarks: .....

Signature: ..... Name: .....

Date: ..... Designation: .....

Please return to:
Epidemiologist, Epidemiology Unit, 231, De Saram Place, Colombo 10

email: epidunit@sltnet.lk Tel: 011-2695112 / 2681548 Fax: 011-2696583