



# 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](mailto:bspb@cdc.gov).

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

**Email:** [bspb@cdc.gov](mailto:bspb@cdc.gov)

**Fax:** (404) 929-1590

**DCIPHER:** contact [bspb@cdc.gov](mailto: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.

<b>Treatment and Outcome</b>	<b>Description</b>
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.

<b>Test &amp; Specimen Information</b> (Please complete a new test section for each laboratory test performed)	<b>Description</b>
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., <i>B. anthracis</i> ) was identified in the sample.

<b>Supplemental</b>	<b>Description</b>
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.

<b>Module 1: Outbreak/Known Exposure</b>	<b>Description</b>
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.

<b>Module 2: Unknown Exposure</b>	<b>Description</b>
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.

<b>Module 3: Animal Exposure</b>	<b>Description</b>
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.

<b>Module 4: Metal Exposure</b>	<b>Description</b>
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.

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

<b>Module 6: Antimicrobial Susceptibility</b>	<b>Description</b>
<b>Antimicrobial Susceptibility Testing</b>	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 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 Black or African American Other: \_\_\_\_\_ Ethnicity: Hispanic  
 Asian Native Hawaiian or Pacific Islander \_\_\_\_\_ Non-Hispanic  
 White Unknown \_\_\_\_\_ Unknown  
 Occupation: \_\_\_\_\_ Other: \_\_\_\_\_  
 Employer name: \_\_\_\_\_ Occupation state or territory: \_\_\_\_\_

## CASE INFORMATION

Case Classification:	Classification determined by (select all that apply):	Suspected primary route of infection (select all that apply):
Confirmed	Lab Result	Cutaneous
Not a case	N/A	Injection
Probable	Epi link	Inhalation
Unknown	Unknown	Unknown
Suspect	Clinical Presentation	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	Long-term disability	Where did the death occur?	Was an autopsy performed?	
	Still sick (outpatient)	Died	Home	Yes	No
	Recovered	Unknown	ED	Unknown	Unknown
			Hospital		
			Nursing Facility		
Date of death: _____			Specify other: _____		

<b>Were antibiotics prescribed or administered to this patient for treatment of this illness?</b>		Yes	No	Unknown
<b>Antibiotics prescribed (select all that apply)</b>				
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: _____	

<b>Was antitoxin administered to the patient?</b>		<b>Specify antitoxin:</b>		<b>Date last dose received:</b> _____	
Yes	No	Unknown	AIG Raxibacumab	Obiltoximab Unknown	

<b>Did the patient ever receive anthrax vaccine?</b>		<b>If Pre-Exposure, Date last dose received:</b> _____		<b>Date dose 1:</b> _____	
Yes	No	Unknown			
<b>If Yes,</b>		<b>If Post-Exposure, was the treatment:</b>		<b>Date dose 2:</b> _____	
Pre-Exposure	Post-Exposure	Unknown	AVA	AVA Adjuvanted	Unknown
				<b>Date dose 3:</b> _____	

<b>Were antibiotics prescribed or administered to this patient for prevention of illness (i.e. prophylaxis)?</b>		Yes	No	Unknown
<b>Antibiotic prophylaxis prescribed (select all that apply):</b>				
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					
<b>Test Type:</b>	PCR Culture	Serology Lethal factor	Immunostaining MLVA	WGS Other: _____	
<b>Performing lab:</b>	CDC SPHL	Other LRN Commercial Lab	Unknown Other	<b>Performing laboratory name:</b> _____	
<b>Specimen type:</b>	Whole blood Serum Isolate Pleural/ascites	Cerebrospinal fluid Swab Tissue Other	<b>Specify other:</b> _____	<b>Specify tissue type:</b> _____	<b>Collection date:</b> _____
<b>Qualitative result:</b>	Positive	Negative	Indeterminate	Borderline	Other: _____
<b>Quantitative result:</b>	Result: _____		Other result (wgs/mlva): _____		
	<b>Organism:</b>	<i>Bacillus anthracis</i> <i>Bacillus cereus</i>	<i>Bacillus spp</i> Other	<b>Specify other:</b> _____	
	<b>Result Date:</b> _____	<b>Specimen collected before antibiotic treatment?</b>		Yes	No
				Unknown	

2nd Test & Specimen					
<b>Test Type:</b>	PCR Culture	Serology Lethal factor	Immunostaining MLVA	WGS Other: _____	
<b>Performing lab:</b>	CDC SPHL	Other LRN Commercial Lab	Unknown Other	<b>Performing laboratory name:</b> _____	
<b>Specimen type:</b>	Whole blood Serum Isolate Pleural/ascites	Cerebrospinal fluid Swab Tissue Other	<b>Specify other:</b> _____	<b>Specify tissue type:</b> _____	<b>Collection date:</b> _____
<b>Qualitative result:</b>	Positive	Negative	Indeterminate	Borderline	Other: _____
<b>Quantitative result:</b>	Result: _____		Other result (wgs/mlva): _____		
	Organism:	<i>Bacillus anthracis</i> <i>Bacillus cereus</i>	<i>Bacillus spp</i> Other	<b>Specify other:</b> _____	
	Result Date: _____	Specimen collected before antibiotic treatment?		Yes	No      Unknown
3rd Test & Specimen					
<b>Test Type:</b>	PCR Culture	Serology Lethal factor	Immunostaining MLVA	WGS Other: _____	
<b>Performing lab:</b>	CDC SPHL	Other LRN Commercial Lab	Unknown Other	<b>Performing laboratory name:</b> _____	
<b>Specimen type:</b>	Whole blood Serum Isolate Pleural/ascites	Cerebrospinal fluid Swab Tissue Other	<b>Specify other:</b> _____	<b>Specify tissue type:</b> _____	<b>Collection date:</b> _____
<b>Qualitative result:</b>	Positive	Negative	Indeterminate	Borderline	Other: _____
<b>Quantitative result:</b>	Result: _____		Other result (wgs/mlva): _____		
	Organism:	<i>Bacillus anthracis</i> <i>Bacillus cereus</i>	<i>Bacillus spp</i> Other	<b>Specify other:</b> _____	
	Result Date: _____	Specimen collected before antibiotic treatment?		Yes	No      Unknown

**Notes:**

**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 <i>(e.g., bus, train, ferry, light rail, subway, rideshare)</i>	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) Other: \_\_\_\_\_  
Annual vaccination (vaccinated yearly regardless of risk) 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	R100	Cloth mask/face mask	Boots
N95	P95	Goggles	Gloves
N99	P99	Fire/Flame-resistant clothing	Unknown
N100	P100	Earmuffs/plugs	Other: _____
R95	Other respirator: _____		
R99			

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

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

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      Specify other antimicrobial tested:  
 Ciprofloxacin      Imipenem      Moxifloxacin      Other      \_\_\_\_\_  
 Clarithromycin      Levofloxacin      Penicillin  
 Clindamycin      Linezolid      Tetracycline

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      Specify other antimicrobial tested:  
 Ciprofloxacin      Imipenem      Moxifloxacin      Other      \_\_\_\_\_  
 Clarithromycin      Levofloxacin      Penicillin  
 Clindamycin      Linezolid      Tetracycline

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

<b>Antimicrobial susceptibility tested</b>					
Amoxicillin	Doxycycline	Meropenem	Vancomycin	<b>Specify other antimicrobial tested:</b>	
Ciprofloxacin	Imipenem	Moxifloxacin	Other	_____	
Clarithromycin	Levofloxacin	Penicillin			
Clindamycin	Linezolid	Tetracycline			
<b>Antimicrobial susceptibility test type. <i>Select all that apply.</i></b>					
E-test	BMD	Rapid	Other	<b>Specify other:</b> _____	
<b>Result/Interpretation</b>	MIC (ug/ml): _____	Susceptible	Resistant	Not susceptible	No CLSI breakpoint
<b>Antimicrobial susceptibility tested</b>					
Amoxicillin	Doxycycline	Meropenem	Vancomycin	<b>Specify other antimicrobial tested:</b>	
Ciprofloxacin	Imipenem	Moxifloxacin	Other	_____	
Clarithromycin	Levofloxacin	Penicillin			
Clindamycin	Linezolid	Tetracycline			
<b>Antimicrobial susceptibility test type. <i>Select all that apply.</i></b>					
E-test	BMD	Rapid	Other	<b>Specify other:</b> _____	
<b>Result/Interpretation</b>	MIC (ug/ml): _____	Susceptible	Resistant	Not susceptible	No CLSI breakpoint