

# CDC Case Report Form: Serious Adverse Events Following Ceftriaxone Injection in Healthcare Settings

Form Approved  
OMB Control No. 0920-1011  
Expiration Date: 12/31/2025

This form is intended to be completed by a healthcare provider or a healthcare facility staff member, coroner, medical examiner, or public health professional in conjunction with a healthcare provider. The purpose of this form is to report a serious adverse event after administration of ceftriaxone injection. If you are a patient and want to report an adverse event related to ceftriaxone injection, please speak with your medical provider.

A serious adverse event is defined by the Food and Drug Administration as any undesirable experience associated with the use of a medical product in a patient, including:

- Death
- Life-threatening outcome
- Hospitalization (initial or prolonged)
- Outcomes which required intervention to prevent permanent impairment or damage
- Other serious events (including allergic bronchospasm or serious problems with breathing)

For additional information from the Food and Drug Administration on the definition of serious adverse events, please view: <https://www.fda.gov/safety/reporting-serious-problems-fda/what-serious-adverse-event>

Please note that completing this form does not replace reporting adverse events to FDA's MedWatch or to the manufacturer directly. The online form to file a MedWatch report can be found here: <https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home>

## Reporter Information

Reporter name

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Reporter phone number

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Reporter email

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Reporter fax number

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Name of reporter's workplace

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Reporter work address

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Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA 0920-1011

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Reporter city

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Reporter zip code

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Reporter county

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Reporter state

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

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Reporter type

- Coroner
- Hospital
- Outpatient facility
- Health department
- Other

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If other, please specify

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**Patient Demographics**

Patient age

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Patient sex

- Male
- Female

Patient county of residence

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Patient state of residence

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
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- Utah
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- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

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### Serious Adverse Event Information

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Please use the following information to help guide selection of the particular serious event type:

- Death: Check if the patient died after receiving the medical product.

- Life-threatening outcome: Check if you suspect that the patient was at substantial risk of dying at the time of the adverse event, or if continued use of the medical product might have resulted in the death of the patient.

- Hospitalization (initial or prolonged): Check if admission to the hospital or prolongation of hospitalization was a result of the adverse event.

- Outcomes which required intervention to prevent permanent impairment or damage: Check if you believe that medical or surgical intervention was delivered to prevent permanent impairment of a body function or prevent permanent damage to a body structure due to the use of a medical product.

- Other serious or important medical events: Check when the event does not fit the other outcomes, but the event could have jeopardized the patient and could have required medical or surgical intervention (treatment) to prevent one of the other outcomes. Examples include allergic bronchospasm (a serious problem with breathing) requiring treatment in an emergency room.

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Please choose the type of serious adverse event

(Note: Please choose the most serious adverse event type applicable)

- Death  
 Life-threatening outcome  
 Hospitalization (initial or prolonged)  
 Outcomes which required intervention to prevent permanent impairment or damage  
 Other serious or important medical events

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DATE of most recent dose of ceftriaxone received?

\_\_\_\_\_

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TIME of most recent dose of ceftriaxone if known  
(please enter in 24-hour time format)

Note: For outpatient facilities, if the timing of administration is not documented, please record estimated time of ceftriaxone administration from the treating provider.

\_\_\_\_\_

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Healthcare facility type where ceftriaxone was administered

- Outpatient clinic (including primary care clinics)  
 Urgent care clinic  
 Ambulatory surgery center  
 Emergency department  
 Acute care hospital, excluding emergency department and ICU  
 Acute care hospital ICU  
 Long term acute care hospital  
 Skilled nursing facility  
 Assisted living facility  
 Rehab facility  
 Other

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If other, please specify

\_\_\_\_\_

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DATE of adverse event onset

(Note: Please specify date when new or worsening symptoms occurred after ceftriaxone administration)

\_\_\_\_\_

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TIME of adverse event onset (Note: please enter in 24-hour time format)  
(Note: Please specify time when new or worsening symptoms occurred after ceftriaxone administration)

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Did the onset of the serious adverse event within 6 hours of receiving ceftriaxone?

- Yes  
 No  
 Unknown
- 

In which setting did the adverse event occur?

- Community setting (ex: home, store, restaurant, etc.)  
 Outpatient clinic (including primary care clinics)  
 Urgent care clinic  
 Ambulatory surgery center  
 Emergency department  
 Acute care hospital, excluding emergency department and ICU  
 Acute care hospital ICU  
 Long term acute care hospital  
 Skilled nursing facility  
 Assisted living facility  
 Rehab facility  
 Other
- 

If other setting of adverse event, please specify

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Did EMS evaluate the patient?

- Yes  
 No  
 Unknown
- 

Was the patient transferred to a higher level of care as a result of this severe adverse event? (If "No" or "Unknown", please skip to question about signs and symptoms of serious adverse event)

- Yes  
 No  
 Unknown
- 

If patient transferred to a higher level of care, what was the highest level of care the patient received for management of the adverse event?

- Treatment in urgent care or outpatient clinic  
 Treatment in emergency department (for cases where patient was not admitted to hospital after emergency department evaluation)  
 Treatment in acute care hospital (excluding emergency department or ICU)  
 Treatment in ICU  
 Other (specify)
- 

If "other" selected for highest level of care, please specify

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If the patient was evaluated in an outpatient setting or in emergency department, what was the disposition after care?

- Discharged home  
 Transferred to another facility  
 Death  
 Other
- 

If "other" selected for question above, please specify

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If the patient was hospitalized or if "other" selected for higher level of care, what was the disposition after care?

- Discharged home  
 Discharged or transferred to another facility  
 Still receiving care inpatient  
 Death  
 Other

If "other" selected for question above, please specify

Signs and symptoms of serious adverse event (select all that apply)

- Facial swelling  
 Urticaria (hives)  
 Low blood pressure  
 Bradycardia  
 Tachycardia  
 Palpitations  
 Nausea  
 Shortness of breath  
 Vomiting  
 Tingling  
 Flushing  
 Diaphoresis  
 Abdominal pain  
 Diarrhea  
 Loss of consciousness  
 Chills  
 Fever  
 Difficulty swallowing  
 Wheezing  
 Found unresponsive  
 Throat closing  
 Tongue itching  
 Cough  
 Hypoxia  
 Headache  
 Chest pain  
 Strange taste  
 Other

If other sign or symptom of serious adverse event, please list here

Was the adverse event suspected to be an allergic (immunologically-mediated) reaction? (Select yes if an allergic reaction is suspected OR if event clinically managed as an allergic reaction)

- Yes  
 No

Did the patient receive cardiopulmonary resuscitation (CPR) as a result of the serious adverse event?

- Yes  
 No

Note: For the purpose of this form, CPR is defined as cardiopulmonary resuscitation defined as the use of chest compressions and mechanical ventilation or provision of rescue breaths to maintain circulatory flow and oxygenation during cardiac arrest.

If CPR selected, enter DATE CPR was initiated

If CPR selected, enter TIME CPR was initiated (Note: please enter in 24-hour time format)



Does the treating provider attribute the adverse event to a cause OTHER than ceftriaxone administration?

- Adverse event attributed to a cause other than ceftriaxone administration (such as known infection, other underlying medical condition, or exposure to a medication or medical product other than ceftriaxone)
- Adverse event NOT attributed to a cause other than ceftriaxone administration

Does the treating provider attribute the adverse event to ceftriaxone administration?

- Yes
- No
- Provider not sure

If the adverse event is suspected to be from ceftriaxone, is it a known adverse effect of ceftriaxone?

- Yes
- No
- Adverse event not suspected to be from ceftriaxone

Note: Major known adverse effects of ceftriaxone are listed below. For other known adverse events of ceftriaxone, please refer to the ceftriaxone product label corresponding to the NDC number and manufacturer administered to this patient

here: <https://dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=all&query=ceftriaxone>

Major known adverse effects of ceftriaxone include:

- Local reactions: Pain, induration and tenderness was 1% overall. Phlebitis was reported in < 1% after IV administration.
- Hypersensitivity: Rash (1.7%). Less frequently reported (< 1%) were pruritus, fever or chills.
- Infections and infestations: Genital fungal infection (0.1%).
- Hematologic: Eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (< 1%) were anemia, hemolytic anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.
- Blood and lymphatic disorders: Granulocytopenia (0.9%), coagulopathy (0.4%).
- Gastrointestinal: Diarrhea/loose stools (2.7%). Less frequently reported (< 1%) were nausea or vomiting, and dysgeusia. The onset of pseudomembranous colitis symptoms may occur during or after antibacterial treatment.
- Hepatic: Elevations of aspartate aminotransferase (AST) (3.1%) or alanine aminotransferase (ALT) (3.3%). Less frequently reported (< 1%) were elevations of alkaline phosphatase and bilirubin.
- Renal: Elevations of the BUN (1.2%). Less frequently reported (< 1%) were elevations of creatinine and the presence of casts in the urine.
- Central nervous system: Headache or dizziness were reported occasionally (< 1%).
- Genitourinary: Moniliasis or vaginitis were reported occasionally (< 1%).
- Miscellaneous: Diaphoresis and flushing were reported occasionally (< 1%).
- Investigations: Blood creatinine increased (0.6%).

Post-market adverse experiences reported:

- Gastrointestinal: Pancreatitis, stomatitis and glossitis.
- Genitourinary: Oliguria, ureteric obstruction, post-renal acute renal failure.
- Dermatologic: Exanthema, allergic dermatitis, urticaria, edema; acute generalized exanthematous pustulosis (AGEP) and isolated cases of severe cutaneous adverse reactions (erythema multiforme, Stevens-Johnson syndrome or Lyell's syndrome/toxic epidermal necrolysis) have been reported.
- Hematological changes: Isolated cases of agranulocytosis (< 500/mm ) have been reported, most of them after 10 days of treatment and following total doses of 20 g or more.
- Nervous system disorders: Convulsion
- Other: Symptomatic precipitation of ceftriaxone calcium salt in the gallbladder, kernicterus, oliguria, and anaphylactic or anaphylactoid reactions. Source: <https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=8351aa37-552d-471d-b293-c564dcb6ec29>

Other:

- The combination of lansoprazole and ceftriaxone has been associated with prolonged corrected QT (QTc) intervals. Citations: Bai AD, Wilkinson A, Almufleh A, et al. Ceftriaxone and the Risk of Ventricular Arrhythmia, Cardiac Arrest, and Death Among Patients Receiving Lansoprazole. JAMA Netw Open. 2023;6(10):e2339893. doi:10.1001/jamanetworkopen.2023.39893;

Lorberbaum T, Sampson KJ, Chang JB, Iyer V, Woosley RL, Kass RS, Tatonetti NP. Coupling Data Mining and Laboratory Experiments to Discover Drug Interactions Causing QT Prolongation. J Am Coll Cardiol. 2016 Oct 18;68(16):1756-1764. doi: 10.1016/j.jacc.2016.07.761. PMID: 27737742; PMCID: PMC5082283.

If the adverse event was attributed to a cause other than ceftriaxone administration, what was the suspected cause of the adverse event?

- Adverse event secondary to another medication other than ceftriaxone (please specify below)  
 Active infection (please specify below)  
 Other medical diagnosis (please specify below)

If the primary cause of the adverse event is suspected to be a medication other than ceftriaxone, please specify that medication here

\_\_\_\_\_

If the primary cause of the adverse event is suspected to be an active infection, please specify the infection here

\_\_\_\_\_

If the primary cause of the adverse event is suspected to be another medical diagnosis, please specify the medical diagnosis here

\_\_\_\_\_

Is patient deceased? (If no, please skip to next section on EKG information)

- Yes  
 No

DATE of death

\_\_\_\_\_

TIME of death if known (Note: please enter in 24-hour time format)

\_\_\_\_\_

Recorded cause of death in medical record or death certificate

\_\_\_\_\_

Per treating provider or clinician, was this death in an apparently healthy patient or patient whose disease is not so severe that a fatal outcome would be expected?

- Yes  
 No

Was autopsy performed?

- Yes  
 No  
 Unknown

Please note that autopsy findings are critical to evaluate unexpected deaths which are suspected to be related to a medical product exposure. Please reach out to CDC at [haioutbreak@cdc.gov](mailto:haioutbreak@cdc.gov) with any questions regarding autopsy.

If autopsy was performed, what were significant findings?

\_\_\_\_\_

Was a toxicology screen performed?

- Yes  
 No  
 Unknown

If toxicology screen was performed, what were significant findings? \_\_\_\_\_

**Vital Signs Information**

What were the patient's vital signs BEFORE the onset of the adverse event? (If vital signs are documented more than once before adverse event, please report those recorded most recently before onset)

Heart rate (beats per minute) \_\_\_\_\_  
Respiratory rate (breaths per minute) \_\_\_\_\_  
Systolic blood pressure (mmHg) \_\_\_\_\_  
Diastolic blood pressure (mmHg) \_\_\_\_\_  
Oxygen saturation (%) \_\_\_\_\_  
Temperature (degrees Fahrenheit) \_\_\_\_\_

What were the patient's vital signs AFTER the onset of the adverse event? (If vital signs are documented more than once after adverse event, please report those recorded most recently after onset)

Heart rate (beats per minute) \_\_\_\_\_  
Respiratory rate (breaths per minute) \_\_\_\_\_  
Systolic blood pressure (mmHg) \_\_\_\_\_  
Diastolic blood pressure (mmHg) \_\_\_\_\_  
Oxygen saturation (%) \_\_\_\_\_  
Temperature (degrees Fahrenheit) \_\_\_\_\_

**EKG, Rhythm Strip, or Defibrillator Recording Information**

Was an EKG, rhythm strip, or defibrillator recording collected during the severe adverse event? (If "No" or "Unknown", please skip to next section on patient medical information)  Yes  No  Unknown

What was the heart rate? \_\_\_\_\_

If computerized reading available, what was the PR interval? \_\_\_\_\_

If computerized reading available, what was the QRS duration? \_\_\_\_\_

If computerized reading available, what was the QT interval? \_\_\_\_\_

If computerized reading available, what was the QTc interval? \_\_\_\_\_

Please select any EKG, rhythm strip, or defibrillator recording findings that apply

- Normal sinus rhythm
- Sinus tachycardia
- Sinus bradycardia
- Atrial fibrillation
- Atrial flutter
- Supraventricular tachycardia
- Ventricular fibrillation
- Ventricular tachycardia
- ST elevation
- Right bundle branch block
- Left bundle branch block
- QT prolongation
- Other

If other EKG findings (or to elaborate on previous selected findings), please list here

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### Patient Medical Information

Patient's medical history (select all that apply)

- COPD/emphysema/chronic lung disease
- Asthma
- Diabetes
- Congestive heart failure
- Coronary arterial disease (including history of myocardial infarction, coronary stents, or coronary artery bypass graft [CABG] surgery)
- Chronic renal insufficiency (CRI/CKD) or end-stage renal disease (ESRD)
- Cirrhosis/liver disease
- History of stroke/CVA
- Dementia
- HIV/AIDS
- Cancer (specify in next question)
- Allergy to penicillin
- Hypothyroidism
- Psychiatric illness
- Hypertension
- Hyperlipidemia
- Tobacco use
- Alcohol use disorder
- Hyperthyroidism
- Arrhythmia (ex: atrial fibrillation)
- Gastroesophageal reflux disease (GERD)
- Other

If other medical history, please list here:

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List all the medications that the patient was taking at the time of the serious adverse event. Please use generic names of medications. Please separate medications by a semi-colon (ex: aspirin; atorvastatin; metoprolol). If no other medications, please state "none".

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**Ceftriaxone Information**

Manufacturer of most recent dose of ceftriaxone received \_\_\_\_\_

NDC (National Drug Code) number of ceftriaxone received \_\_\_\_\_  
Note: This is a 10-digit number found on the medication vial.

Lot number of most recent dose of ceftriaxone received \_\_\_\_\_

Was this lot number documented as administered to the patient or present in the facility at the time of ceftriaxone administration (but not documented in the medical record as administered to patient)?

- Documented as administered to the patient  
 Present in facility at time of administration  
 Other

If other selected for above question, please specify \_\_\_\_\_

If lot number was present in the facility at time of administration (but not documented in the medical record as administered to patient), please list any other manufacturers and lot numbers of ceftriaxone present in the facility at the time of administration \_\_\_\_\_

Expiration date of most recent dose of ceftriaxone received \_\_\_\_\_

Dose of most recent ceftriaxone injection

- 1 g  
 2 g  
 Other (please specify)

For other dose of ceftriaxone, please specify \_\_\_\_\_

Route of administration of ceftriaxone

- Intramuscular (IM)  
 Intravenous (IV) infusion  
 Intravenous (IV) push  
 Unknown

Which diluent was used to prepare the ceftriaxone injection?

- Sterile water
- 0.9% Sodium chloride
- 1% Lidocaine solution without epinephrine
- Bacteriostatic water + 0.9% benzyl alcohol
- 5% Dextrose
- 10% Dextrose
- 5% Dextrose + 0.9% Sodium Chloride Solution
- 5% Dextrose + 0.45% Sodium Chloride Solution
- Sodium lactate
- 10% Invert sugar
- 5% Sodium bicarbonate
- Freamine III
- Normosol-M in 5% dextrose
- Ionosol-B in 5% dextrose
- 5% Mannitol
- 10% Mannitol
- No other diluent used
- Unknown
- Other (specify)

If other diluent used, please specify

\_\_\_\_\_

Reason for ceftriaxone treatment

- Pneumonia
- COPD exacerbation
- Other respiratory illness (please specify)
- Urinary tract infection
- Sexually transmitted infection
- Skin and soft tissue infection
- Bloodstream infection
- Intra-abdominal infection
- Other (please specify)

If "other respiratory illness" or "other" chosen for reason for ceftriaxone treatment, please specify

\_\_\_\_\_

List any other medications and route of administration provided at the same time as ceftriaxone (ex: dexamethasone intramuscular, etc.).

\_\_\_\_\_

Has this patient received ceftriaxone before this incident?

- Yes
- No
- Unknown

If this patient has received ceftriaxone prior to current administration, did the patient experience any adverse events with previous receipt of ceftriaxone?

- Yes
- No
- Unknown

### Respiratory Testing Information

Please answer the following questions if the reason for ceftriaxone administration was for a respiratory illness (pneumonia, COPD exacerbation, or other respiratory illness). If another reason for treatment with ceftriaxone was chosen, please skip to the next section on microbiology test information.

Did the patient have a flu test performed?

- Yes
- No
- Unknown

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If the patient had a flu test performed, what was the result?

Flu A positive  
 Flu B positive  
 Flu negative

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Did the patient have a covid test performed?

Yes  
 No  
 Unknown

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If the patient had a covid test performed, what were the results?

Covid test positive  
 Covid test negative

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Note: The following four questions are to be completed for patients diagnosed with pneumonia.

#### CURB-65 Pneumonia Severity Score Questions

The following four questions are derived from the CURB-65 Pneumonia Severity Score tool which helps stratify risk for more severe outcomes from community-acquired pneumonia.

Citation: Lim WS, van der Eerden MM, Laing R, Boersma WG, Karalus N, Town GI, Lewis SA, Macfarlane JT. Defining community acquired pneumonia severity on presentation to hospital: an international derivation and validation study. *Thorax*. 2003 May;58(5):377-82. doi: 10.1136/thorax.58.5.377. PMID: 12728155; PMCID: PMC1746657.

	Yes	No	Unknown
Was the patient confused (e.g., disoriented to time, place, or person) prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the patient's blood urea nitrogen (BUN) level 20 mg/dL or higher prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was the patient's respiratory rate 30 breaths per minute or higher prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Was the patient's systolic blood pressure less than 90 mmHg, or diastolic blood pressure less than 60 mmHg prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)

**Microbiology Test Information**

Please answer the following questions about any positive microbiology results within 2 days of the adverse event.

If there are no microbiology results to report, please skip to the next section on picture upload.

Microbiology test #1 name (ex: respiratory viral panel, stool culture, etc.)

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Microbiology test #1 specimen source

- Nasal or oropharyngeal
- Sputum
- Blood
- Urine
- Stool
- Wound
- Other

If other specimen for microbiology test #1, please specify

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Microbiology test #1 type

- Culture
- Gram stain
- NAAT (including PCR)
- Other

If other test type for microbiology test #1, please specify

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Microbiology test #1 result

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Microbiology test #2 name (ex: respiratory viral panel, stool culture, etc.)

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Microbiology test #2 specimen source

- Nasal or oropharyngeal
- Sputum
- Blood
- Urine
- Stool
- Wound
- Other

If other specimen for microbiology test #2, please specify

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Microbiology test #2 type

- Culture  
 Gram stain  
 NAAT (including PCR)  
 Other

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If other test type for microbiology test #2, please specify

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Microbiology test #2 result

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Microbiology test #3 name (ex: respiratory viral panel, stool culture, etc.)

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Microbiology test #3 specimen source

- Nasal or oropharyngeal  
 Sputum  
 Blood  
 Urine  
 Stool  
 Wound  
 Other

---

If other specimen for microbiology test #3, please specify

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Microbiology test #3 type

- Culture  
 Gram stain  
 NAAT (including PCR)  
 Other

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If other test type for microbiology test #3, please specify

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Microbiology test #3 result

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If additional microbiology tests, please list with name, specimen source, test type, and result

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### Picture Upload

Upload pictures of ceftriaxone vial of most recent dose if available. Ideally include front label of bottle and lot number.

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Ceftriaxone vial picture #1

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Ceftriaxone vial picture #2

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Ceftriaxone vial picture #3

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Upload picture of medication vials/containers coadministered with ceftriaxone if available (ex: lidocaine, saline). Ideally include front label and lot number.

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Other medical vials/containers picture #1

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Other medical vials/containers picture #2

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Other medical vials/containers picture #3

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**Healthcare Facility Information**

Healthcare facility name where ceftriaxone was administered

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Street address of healthcare facility where ceftriaxone was administered

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City of healthcare facility where ceftriaxone was administered

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State of healthcare facility where ceftriaxone was administered

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

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Zip code of healthcare facility where ceftriaxone was administered

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