

Diphtheria

COUNTY

FOR STATE USE ONLY

#

- RESPIRATORY
- CUTANEOUS
- CARRIER
- CASE

Date investigation initiated _____

____/____/____ case report

____/____/____ interstate

- confirmed
- presumptive
- suspect

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County State Zip

e-mail address _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

- Lab
- Infection Control Practitioner
- Physician
- _____

Name _____

Phone _____ Date ____/____/____
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC yes no unknown

RACE

- White American Indian
- Black Asian/Pacific Islander
- unknown refused to answer
- other _____

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____
above is: Day/Mo/Yr (circle one)

Worksites/school/day care center _____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

ONSET date ____/____/____
m d y

Check all that apply:

- sore throat yes no unk
- stridor yes no unk
- hoarseness yes no unk
- cervical l.n. enlargement yes no unk
- pharyngitis yes no unk
- pharyngeal membrane yes no unk
- skin ulcers yes no unk
- draining ears yes no unk
- bloody nasal discharge yes no unk
- fever yes no unk

other _____

Hospitalized: yes no unk

name of hospital _____

date of admission ____/____/____

date of discharge ____/____/____

Outcome: survived died unk

date of death ____/____/____

LABORATORY DATA

	Culture		PCR		Gram stain
	pos	neg	pos	neg	
throatswab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Lab _____

serogroup _____

Isolate sent to public health lab? yes no

PHL specimen # _____

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? yes no unk

a close contact of a confirmed or presumptive case? yes no unk

Has the above case been reported? yes no

Specify nature of contact:

household sexual daycare _____

If yes to any question, specify relevant names, dates, places, etc:

IMMUNIZATION HISTORY

Diphtheria vaccine received in past? yes no unknown if yes, complete table:

Vaccine	Date	Provider/Phone	Verified
			yes no
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/> <input type="checkbox"/>

If available, provide details.

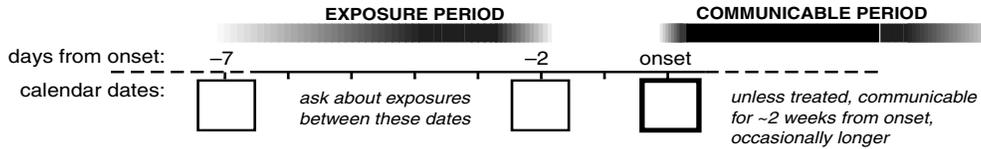
if not vaccinated, why not?

- age less than 2 months
- medical exemption
- religious objection
- "forgot"
- cost too much
- inconvenience
- concurrent illness
- other _____



INFECTION TIMELINE

Enter onset date in box.
Count back to figure probable exposure periods.



RISK FACTORS FOR DISEASE

- Was the patient a contact of a confirmed or presumptive case? yes no *If yes, provide relevant details.*
- if yes, was prophylaxis recommended?* yes no
- Was patient under 5-day surveillance? yes no

Identify possible exposures

- respiratory disease
- treated for nasopharyngeal carriage
- heavy drinker
- If case is a child, is primary caretaker a heavy drinker?* yes no
- travel outside U.S.
- if yes, was vaccine recommended prior to travel?* yes no

CASE-CONTACT MANAGEMENT AND FOLLOW UP

Case education provided? yes no unknown *if yes, date* ___/___/___

Did the patient have daycare, health care, or other prolonged contact with children? yes no

If yes, provide relevant details at right

if yes, was prophylaxis recommended to any contacts? yes no
SEE BELOW

HOUSEHOLD ROSTER

name	age	relation to case	date	vaccination status/last vaccination	education provided			prophylactic treatment of household contacts
					yes	no	unk	
_____	_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Identify persons with **significant** exposure in the 7 days prior to onset who should be offered prophylaxis. Provide details at right.

- household members
- roommates in institutions
- daycare contacts
- playmates, other children
- other patients
- medical personnel
- EMTs
- co-workers
- _____

If EMTs were exposed, was their supervisor notified? yes no

Comments:



ADMINISTRATION

Remember to copy patient's name to the top of this page.

Case report sent to OHS on ___/___/___

Completed by _____ Date _____ Phone _____ Investigation sent to OHS on ___/___/___