West Virginia Bureau for Public Health
Your Health Your Safety Our Purpose
Department of Health & Human Resources

Diphtheria

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade:_____ Employer/School:_____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*_____ *Phone:* _____

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _____ Address: _____ _____ Phone: _____
Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____
Reporter Name: _____ ____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____
Physician Address: _____ Phone: _____

Hospital Was patient hospitalized for this illness? ☐ **Y** ☐ **N** ☐ **U** If yes, Admit date: __ / __ / ____ Discharge date: __ / __ / ____
Hospital name: _____

Condition Diagnosis date: __ / __ / ____ Illness onset date: __ / __ / ____ Illness end date: __/__/____
Outcome: ☐ Recovered, no residue ☐ Recovered, residue ☐ Died ☐ Unknown

Symptoms

Y	N	U	
☐	☐	☐	Membrane If yes, sites: ☐ Conjunctiva ☐ Hard palate ☐ Larynx ☐ Nares ☐ Nasopharynx ☐ Skin ☐ Soft palate ☐ Tonsils
☐	☐	☐	Fever If yes, highest measured temperature ____° ☐ Fahrenheit or ☐ Celsius
☐	☐	☐	Soft tissue swelling (around membrane)
☐	☐	☐	Neck edema If yes: ☐ Submandibular ☐ Midway to clavicle ☐ To clavicle ☐ Below clavicle
			Is edema: ☐ Bilateral ☐ Right side only ☐ Left side only
☐	☐	☐	Difficulty swallowing
☐	☐	☐	Wheezing
☐	☐	☐	Shortness of breath
☐	☐	☐	Sore throat
☐	☐	☐	Change in voice
☐	☐	☐	EKG abnormality
☐	☐	☐	Palatal weakness

Y	N	U	
☐	☐	☐	Tachycardia
☐	☐	☐	Fatigue
☐	☐	☐	Weakness
☐	☐	☐	Stridor
☐	☐	☐	Other (specify): _____

Complications

☐	☐	☐	Any complications
☐	☐	☐	Airway obstruction If yes, date of onset: __/__/____
☐	☐	☐	Intubation required
☐	☐	☐	Myocarditis If yes, date of onset: __/__/____
☐	☐	☐	(Poly)neuritis If yes, date of onset: __/__/____
☐	☐	☐	Other (specify): _____

Description of clinical picture:

INPATIENT TREATMENT

Treated with antibiotics? ☐ **Y** ☐ **N** ☐ **U**
If yes, date started: __/__/____ Duration of therapy (in days):__

Antibiotics given:
☐ Erythromycin (incl pediazole, ilosone)
☐ Amoxicillin/Ampicillin/Augmentin/Celclor/Cefixme
☐ Cotrimoxazole (bactrim/septra)
☐ Penicillin (Bicillin, Pfizerpen-AS, Wycillin)
☐ Clarithromycin/azithromycin ☐ Tetracycline/Doxycycline
☐ Other (specify): _____ ☐ Unknown

OUTPATIENT TREATMENT

Treated with antibiotics? ☐ **Y** ☐ **N** ☐ **U**
If yes, date started: __/__/____ Duration of therapy (in days):__

Antibiotics given:
☐ Erythromycin (incl pediazole, ilosone)
☐ Amoxicillin/Ampicillin/Augmentin/Celclor/Cefixme
☐ Cotrimoxazole (bactrim/septra)
☐ Penicillin (Bicillin, Pfizerpen-AS, Wycillin)
☐ Clarithromycin/azithromycin ☐ Tetracycline/Doxycycline
☐ Other (specify): _____ ☐ Unknown

DIPHTHERIA ANTITOXIN TREATMENT (DAT)

Was diphtheria antitoxin (DAT) administered? ☐ **Y** ☐ **N** ☐ **U** If yes, amount of DAT administered (in IU): _____

Physician requesting DAT, Name: ____ Phone: ____________________________

Address: ____

LABORATORY *(Please submit copies of all labs to DIDE)*

Y N U

☐ ☐ ☐ Specimen for diphtheria culture obtained? If yes, Date specimen collected: __/__/____

Result date: __/__/____ Result: ☐ Positive ☐ Negative ☐ Not Done

If culture positive, biotype: ☐ Belfanti ☐ Gravis ☐ Intermedius ☐ Mitis

If culture positive, results of toxigenicity testing: ☐ Negative ☐ Positive ☐ Unknown ☐ Not Done

Specify lab performing culture: ____

☐ ☐ ☐ Were antibiotics given in the 24 hours before culture?

☐ ☐ ☐ Specimen sent to CDC Diphtheria Lab for confirmation/molecular typing? ☐ Check if a specimen will be sent

Type of specimen: ☐ Clinical swab ☐ Piece of membrane ☐ *C. diphtheriae* isolate

☐ ☐ ☐ Serum specimen for Diphtheria Antitoxin antibodies obtained?

PCR result: ☐ Negative ☐ Positive ☐ Unknown ☐ Not Done

VACCINE INFORMATION

Did the patient receive their childhood primary series? ☐ **Y** ☐ **N** ☐ **U**

If < 18 years of age, Number of doses: ___

Did the patient receive boosters as an adult? ☐ **Y** ☐ **N** ☐ **U** Date of last dose: __/__/____ ☐ Check if date of last dose unknown

VACCINATION RECORD

Date received: __/__/____ Anatomical site: ________________
Vaccine administered: ______________ Vaccine ID: __________
Manufacturer: ________________ Organization ID: __________
Lot #: __________________ Expiration Date: __/__/____

Given by: Last Name: __________________________
First Name: _____________________ Provider ID: ___________
Organization Name: ____________________________________
Organization ID: _________________

Date received: __/__/____ Anatomical site: ________________
Vaccine administered: ______________ Vaccine ID: __________
Manufacturer: ________________ Organization ID: __________
Lot #: __________________ Expiration Date: __/__/____

Given by: Last Name: __________________________
First Name: _____________________ Provider ID: ___________
Organization Name: ____________________________________
Organization ID: _________________

Date received: __/__/____ Anatomical site: ________________
Vaccine administered: ______________ Vaccine ID: __________
Manufacturer: ________________ Organization ID: __________
Lot #: __________________ Expiration Date: __/__/____

Given by: Last Name: __________________________
First Name: _____________________ Provider ID: ___________
Organization Name: ____________________________________
Organization ID: _________________

Date received: __/__/____ Anatomical site: ________________
Vaccine administered: ______________ Vaccine ID: __________
Manufacturer: ________________ Organization ID: __________
Lot #: __________________ Expiration Date: __/__/____

Given by: Last Name: __________________________
First Name: _____________________ Provider ID: ___________
Organization Name: ____________________________________
Organization ID: _________________

Date received: __/__/____ Anatomical site: ________________
Vaccine administered: ______________ Vaccine ID: __________
Manufacturer: ________________ Organization ID: __________
Lot #: __________________ Expiration Date: __/__/____

Given by: Last Name: __________________________
First Name: _____________________ Provider ID: ___________
Organization Name: ____________________________________
Organization ID: _________________

Date received: __/__/____ Anatomical site: ________________
Vaccine administered: ______________ Vaccine ID: __________
Manufacturer: ________________ Organization ID: __________
Lot #: __________________ Expiration Date: __/__/____

Given by: Last Name: __________________________
First Name: _____________________ Provider ID: ___________
Organization Name: ____________________________________
Organization ID: _________________

EPIDEMIOLOGIC

Y N U

☐ ☐ ☐ Is this case epi-linked to a diphtheria case or carrier? If yes, case ID of epi-linked case: __________

☐ ☐ ☐ Does this case have a known exposure to international travelers?

☐ ☐ ☐ Does this case have a known exposure to immigrants?

☐ ☐ ☐ Is this case part of a cluster or outbreak? If yes, name of outbreak? _________________

Case's country of residence: ☐ USA ☐ Other (specify): ___________________________ Date of US arrival: __/__/____

Transmission Setting (where did this case acquire diphtheria?): ☐ Other (specify): ____________________________________

☐ Athletics	☐ College	☐ Community	☐ Correctional facility
☐ Daycare	☐ Doctor's office	☐ Home	☐ Hospital ER
☐ Hospital outpatient clinic	☐ Hospital ward	☐ International travel	☐ Military
☐ Place of worship	☐ School	☐ Work	☐ Unknown

TRAVEL HISTORY

History of international travel 2 weeks prior to onset? ☐ Y ☐ N ☐ U

Country visited	From (mm/dd/yyyy)	To (mm/dd/yyyy)

History of interstate travel 2 weeks prior to onset? ☐ Y ☐ N ☐ U

State visited	From (mm/dd/yyyy)	To (mm/dd/yyyy)

PUBLIC HEALTH ISSUES

Y N U

☐ ☐ ☐ Case knows someone who had shared exposure and is currently having similar symptoms
☐ ☐ ☐ Epi link to another confirmed case of same condition
☐ ☐ ☐ Case is part of an outbreak
☐ ☐ ☐ Other:

PUBLIC HEALTH ACTIONS

Y N U

☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian
☐ ☐ ☐ Facilitate CDC laboratory confirmation of the diagnosis
☐ ☐ ☐ Initiate isolation of patient
☐ ☐ ☐ Initiate contact tracing (including an assessment of vaccination status)
☐ ☐ ☐ Facilitate laboratory testing of other symptomatic persons who have a shared exposure
☐ ☐ ☐ Provide post-exposure prophylaxis (antibiotics) for contacts
☐ ☐ ☐ Patient is lost to follow-up
☐ ☐ ☐ Other:

NOTES

CLOSE CONTACT INFORMATION

Contact 1: Name: _____ Date of Birth: __/__/____ Age: _____ Relation to Case: _____
Y N U Address: _____ Phone number: _____

☐ ☐ ☐ Vaccinated? If yes, number of lifetime doses: _____ Last dose: ☐ ≤ 5 years ago ☐ > 5 years ago
☐ ☐ ☐ Nasopharyngeal culture obtained? If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown
☐ ☐ ☐ Oropharyngeal (throat) culture obtained If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown

Antibiotic prophylaxis received: ☐ Erythromycin (incl pediazole, ilosone) ☐ Amoxicillin/Ampicillin/Augmentin/Celclor/Cefixime
☐ Cotrimoxazole (Bactrim/Septra) ☐ Penicillin (Bicillin, Pfizerpen-AS, Wycillin) ☐ Clarithromycin/azithromycin
☐ Tetracycline/Doxycycline ☐ Other (specify): _____ ☐ Unknown

Contact 2: Name: _____ Date of Birth: __/__/____ Age: _____ Relation to Case: _____
Y N U Address: _____ Phone number: _____

☐ ☐ ☐ Vaccinated? If yes, number of lifetime doses: _____ Last dose: ☐ ≤ 5 years ago ☐ > 5 years ago
☐ ☐ ☐ Nasopharyngeal culture obtained? If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown
☐ ☐ ☐ Oropharyngeal (throat) culture obtained If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown

Antibiotic prophylaxis received: ☐ Erythromycin (incl pediazole, ilosone) ☐ Amoxicillin/Ampicillin/Augmentin/Celclor/Cefixime
☐ Cotrimoxazole (Bactrim/Septra) ☐ Penicillin (Bicillin, Pfizerpen-AS, Wycillin) ☐ Clarithromycin/azithromycin
☐ Tetracycline/Doxycycline ☐ Other (specify): _____ ☐ Unknown

Contact 3: Name: _____ Date of Birth: __/__/____ Age: _____ Relation to Case: _____
Y N U Address: _____ Phone number: _____

☐ ☐ ☐ Vaccinated? If yes, number of lifetime doses: _____ Last dose: ☐ ≤ 5 years ago ☐ > 5 years ago
☐ ☐ ☐ Nasopharyngeal culture obtained? If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown
☐ ☐ ☐ Oropharyngeal (throat) culture obtained If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown

Antibiotic prophylaxis received: ☐ Erythromycin (incl pediazole, ilosone) ☐ Amoxicillin/Ampicillin/Augmentin/Celclor/Cefixime
☐ Cotrimoxazole (Bactrim/Septra) ☐ Penicillin (Bicillin, Pfizerpen-AS, Wycillin) ☐ Clarithromycin/azithromycin
☐ Tetracycline/Doxycycline ☐ Other (specify): _____ ☐ Unknown

Contact 4: Name: _____ Date of Birth: __/__/____ Age: _____ Relation to Case: _____
Y N U Address: _____ Phone number: _____

☐ ☐ ☐ Vaccinated? If yes, number of lifetime doses: _____ Last dose: ☐ ≤ 5 years ago ☐ > 5 years ago
☐ ☐ ☐ Nasopharyngeal culture obtained? If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown
☐ ☐ ☐ Oropharyngeal (throat) culture obtained If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown

Antibiotic prophylaxis received: ☐ Erythromycin (incl pediazole, ilosone) ☐ Amoxicillin/Ampicillin/Augmentin/Celclor/Cefixime
☐ Cotrimoxazole (Bactrim/Septra) ☐ Penicillin (Bicillin, Pfizerpen-AS, Wycillin) ☐ Clarithromycin/azithromycin
☐ Tetracycline/Doxycycline ☐ Other (specify): _____ ☐ Unknown

Contact 5: Name: _____ Date of Birth: __/__/____ Age: _____ Relation to Case: _____
Y N U Address: _____ Phone number: _____

☐ ☐ ☐ Vaccinated? If yes, number of lifetime doses: _____ Last dose: ☐ ≤ 5 years ago ☐ > 5 years ago
☐ ☐ ☐ Nasopharyngeal culture obtained? If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown
☐ ☐ ☐ Oropharyngeal (throat) culture obtained If yes, date of culture: __/__/____ Result: ☐ Positive ☐ Negative ☐ Unknown

Antibiotic prophylaxis received: ☐ Erythromycin (incl pediazole, ilosone) ☐ Amoxicillin/Ampicillin/Augmentin/Celclor/Cefixime
☐ Cotrimoxazole (Bactrim/Septra) ☐ Penicillin (Bicillin, Pfizerpen-AS, Wycillin) ☐ Clarithromycin/azithromycin
☐ Tetracycline/Doxycycline ☐ Other (specify): _____ ☐ Unknown