CDC Diphtheria Worksheet

PATIENT INFORMATION

Date of Request (Month Day Year)

Name (Last, First)

Birth Date (Month Day Year)

Age (Unk = 999)

Age Type
0 = 0-120 years
1 = 0-11 months
2 = 0-52 weeks
3 = 0-28 days
9 = Age unknown

Sex
M = Male
F = Female
U = Unknown

Pregnant?
Y = Yes
N = No
U = Unknown

Race
N = Native Amer./Alaskan Native
A = Asian/Pacific Islander
B = African American
W = White
O = Other
U = Unknown

Ethnicity
H = Hispanic
N = Not Hispanic
U = Unknown

Address (Street and No.)

County

State

Zip

Phone

Date Symptom Onset (Month Day Year)

Date First Diagnosis (Month Day Year)

Date Hospitalized (Month Day Year)

History of Immunization Against Diphtheria

Childhood Primary Series?
Y = Yes
N = No
U = Unknown

If < 18 Years Old, Number of Doses

Boosters as Adult?
Y = Yes
N = No
U = Unknown

Date of Last Dose (Month Day Year) OR (U = Unk)

Description of Clinical Picture

Outcome
N = Recovered, No Residua
R = Recovered, Residua
D = Died
U = Unknown

CLINICAL INFORMATION

Enter Y = Yes, N = No, or U = Unknown in the Boxes Below Unless Otherwise Indicated

Symptoms

- Fever?
- Sore Throat?
- Difficulty Swallowing?
- Change in Voice?
- Shortness of Breath?
- Weakness?
- Fatigue?
- Other?

Signs

- Fever?
- If Yes, Temp ____.____ °C
- Membrane?
- If Yes, Site(s)
  - Tonsils
  - Soft Palate
  - Hard Palate
  - Larynx
  - Nares
  - Nasopharynx
  - Conjunctiva
  - Skin
- Soft Tissue Swelling? (Around Membrane)
- Neck Edema?
- If Yes
  - B = Bilateral
  - L = Left Side Only
  - R = Right Side Only
- If Yes, Extent
  - S = Submandibular Only
  - M = Midway to Clavicle
  - C = To Clavicle
  - B = Below Clavicle
- Stridor?
- Wheezing?
- Palatal Weakness?
- Tachycardia?
- EKG Abnormalities?

Complications

- Complications?
- Airway Obstruction?
- Date of Onset (Month Day Year)
- Intubation Required?
- Myocarditis?
- Date of Onset (Month Day Year)
- (Poly)neuritis?
- Date of Onset (Month Day Year)
- Other?
- Describe:

LABORATORY

Specimen for Diphtheria Culture Obtained?
Y = Yes
N = No
U = Unknown

If Yes, Obtained on (Month Day Year) OR (U = Unknown)

Culture Result
P = Positive
N = Negative
U = Unknown

Specify Lab Performing Culture:

If Culture Positive, Biotype
M = Mitis
G = Gravis
I = Intermedious
B = Belfanti

If Culture Positive, Results of Toxigenicity Testing
X = Not Done
P = Positive
N = Negative
U = Unknown

Specimen Sent to CDC Diphtheria Lab for Confirmation/Molecular Typing?
Y = Yes
N = No
W = Will be Sent

Type of Specimen (Check All That Apply)
- Clinical Swab
- Piece of Membrane
- *C. diphtheria* Isolate

Serum Specimen for Diphtheria Antitoxin Antibodies Obtained?
Y = Yes
N = No
W = Will be Obtained Prior to DAT

PCR Result
P = Positive
N = Negative
U = Unknown
X = Not Done

ANTIBIOTICS

Treated with Antibiotics?
Y = Yes
N = No

As an Outpatient
If Yes, Date Initiated (Month Day Year)

Antibiotic (See Codes Below)

Duration of Therapy (Days)

Antibiotic Therapy in Hospital?
Y = Yes
N = No

As an Inpatient
If Yes, Date Initiated (Month Day Year)

Antibiotic (See Codes Below)

Duration of Therapy (Days)

Were Antibiotics Given in the 24 Hours Before Culture?
Y = Yes
N = No
U = Unknown

1 = Erythromycin (Incl. Pediazole, Ilosone)
2= Penicillin (Bicillin, Pfizerpen-AS, Wycillin)
3 = Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixime
4 = Clarithromycin/azithromycin
5 = Cotrimoxazole (Bactrim/Septra)
6 = Tetracycline/Doxycycline
7 = Other
9 = Unknown

Note: This Form Has 2 Sides

EXPOSURE

Country of Residence ☐ U = US, O = Other

If Other, Country Name:

Date of US Arrival ☐☐ Month ☐☐ Day ☐☐☐☐ Year OR ☐ U = Unknown

History of International Travel? (2 Weeks Prior to Onset) ☐ Y = Yes, N = No, U = Unknown

Country(s) Visited | From Month Day Year | To Month Day Year

History of Interstate Travel? (2 Weeks Prior to Onset) ☐ Y = Yes, N = No, U = Unknown

State(s) Visited | From Month Day Year | To Month Day Year

Known Exposure to Diphtheria Case or Carrier? ☐ Y = Yes, N = No, U = Unknown

Known Exposure to International Travelers? ☐ Y = Yes, N = No, U = Unknown

Known Exposure to Immigrants? ☐ Y = Yes, N = No, U = Unknown

REPORTING INFORMATION

Has This Suspected Case Been Reported to The State or Local Health Department? ☐ Y = Yes, N = No, U = Unknown

Date Reported to State or Local Health Department ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Person Informed: Phone ☐☐☐-☐☐☐-☐☐☐☐ Fax ☐☐☐-☐☐☐-☐☐☐☐

Reporting Physician: Phone ☐☐☐-☐☐☐-☐☐☐☐ Fax ☐☐☐-☐☐☐-☐☐☐☐

REQUESTING PHYSICIAN

Name

Institution

Street

City | **State** | **Zip**

Phone ☐☐☐-☐☐☐-☐☐☐☐ **Fax** ☐☐☐-☐☐☐-☐☐☐☐

Name of Investigator Under the IND (If Different From Requesting Physician) **Phone** ☐☐☐-☐☐☐-☐☐☐☐ **Fax** ☐☐☐-☐☐☐-☐☐☐☐

SEND DRUG TO

Name

Attn.

Institution

Street

City | **State** | **Zip**

Phone ☐☐☐-☐☐☐-☐☐☐☐ **Fax** ☐☐☐-☐☐☐-☐☐☐☐

DOSE

Amount of DAT Administered: ☐☐☐,☐☐☐ IU DAT

DISPOSITION

Final Diagnosis:

How Was the Final Diagnosis Confirmed?

Final Case Disposition ☐ C = Confirmed, P = Probable, N = Not a Case