



Diphtheria

County _____

LHJ Use ID _____
 Reported to DOH Date ___/___/___
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No DK Date of interview ___/___/___

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y N DK NA
 Fever Highest measured temp: _____ °F
 Type: Oral Rectal Other: _____ Unk
 Moderate to severe sore throat
 Difficulty breathing
 Neck swelling
 Runny nose (coryza)
 Drainage from ears
 Skin ulcer

Predisposing Conditions

Y N DK NA
 Respiratory infection
 Heavy drinker
 If child, parent is heavy drinker

Clinical Findings

Y N DK NA
 Stridor
 Pharyngitis
 Adherent gray nasopharyngeal membrane
 Cervical lymph node enlargement
 Bloody nasal discharge
 Ear drainage
 Myocarditis
 Polyneuritis
 Cutaneous (note that skin lesion alone does not meet definition for reportable diphtheria)

Hospitalization

Y N DK NA
 Hospitalized at least overnight for this illness
 Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___

Hospitalization

Y N DK NA
 Died from illness Death date ___/___/___
 Autopsy Place of death _____

Vaccination

Y N DK NA
 Ever received diphtheria containing vaccine
Number of doses diphtheria vaccine prior to illness: _____
 Dose 1 Type: _____ Date received: ___/___/___
 Dose 2 Type: _____ Date received: ___/___/___
 Dose 3 Type: _____ Date received: ___/___/___
 Dose 4 Type: _____ Date received: ___/___/___
 Dose 5 Type: _____ Date received: ___/___/___
 Dose 6 Type: _____ Date received: ___/___/___
 Vaccine up to date for diphtheria
 Vaccine series not up to date reason:
 Religious exemption
 Medical contraindication
 Philosophical exemption
 Previous infection confirmed by laboratory
 Previous infection confirmed by physician
 Parental refusal
 Other: _____ Unk

Laboratory

Collection date ___/___/___
 Source _____

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

P N I O NT
 C. diphtheriae culture (clinical specimen, not from skin lesion)
 Histopathologic diagnosis of diphtheria

INFECTION TIMELINE

<p><i>Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods</i></p>	<p>Days from onset:</p>	<p>Exposure period</p> <div style="border: 1px solid black; padding: 5px; display: inline-block;">-10 -1</div>	<p>o n s e t</p>	<p>Contagious period*</p> <div style="border: 1px solid black; padding: 5px; display: inline-block;">≤14 days</div>
	Calendar dates:	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> <div style="border: 1px solid black; width: 40px; height: 20px;"></div> </div>		<p><small>* Rare chronic carriers may shed organism for 6+ months. If treated, shedding terminates promptly after initiation of effective antibiotic therapy.</small></p>

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Destinations/Dates: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the case know anyone else with similar symptoms or illness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologically linked directly to a culture or PCR confirmed case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with lab confirmed case Age of person from whom this case contracted diphtheria: ____ days/months/years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Work or volunteer in health care setting or as EMT during exposure period Facility name: _____</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congregate living Type: <input type="checkbox"/> Barracks <input type="checkbox"/> Corrections <input type="checkbox"/> Long term care <input type="checkbox"/> Dormitory <input type="checkbox"/> Boarding school <input type="checkbox"/> Camp <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____</p> <p><input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Exposure setting identified: <input type="checkbox"/> Child care <input type="checkbox"/> School <input type="checkbox"/> Doctor's office <input type="checkbox"/> Hospital ward <input type="checkbox"/> Hospital ER <input type="checkbox"/> Hospital outpatient clinic <input type="checkbox"/> Home <input type="checkbox"/> College <input type="checkbox"/> Work <input type="checkbox"/> Military <input type="checkbox"/> Correction facility <input type="checkbox"/> Church <input type="checkbox"/> International travel <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized milk (cow)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other unpasteurized milk (e.g. sheep, goat)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized dairy products (e.g. soft cheese from raw milk, queso fresco or food made with these cheeses)</p>
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Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PATIENT PROPHYLAXIS/TREATMENT

Y N DK NA

Antibiotics prescribed for this illness Name: _____
 Date/time antibiotic treatment began: ___/___/___ AM PM # days antibiotic actually taken: _____

Diphtheria antitoxin given Date/time given: ___/___/___ AM / PM

PUBLIC HEALTH ISSUES

Y N DK NA

Work/volunteer in health care setting while contagious: Facility name: _____

Visited health care setting while contagious
 Facility name: _____
 Number of visits: _____ Date(s): ___/___/___

Face to face contact with newborns, unimmunized children, women > than 7 months pregnant or others at risk for severe complications

Employed in child care or preschool

Attends child care or preschool

Household member or close contact in sensitive occupation or setting (HCW, child care, food)

Documented transmission from this case
 Child care School Doctor's office
 Hospital ward Hospital ER
 Hospital outpatient clinic Home
 College Work Military
 Correction facility Church
 International travel Other: _____ Unk

PUBLIC HEALTH ACTIONS

Prophylaxis of appropriate contacts recommended
 Number of contacts receiving prophylaxis: _____
 Number of contacts recommended prophylaxis: _____
 Number of contacts completing prophylaxis: _____

Strict respiratory isolation until 48 hours of treatment completed or for 14 days

NOTES

Investigator _____	Phone/email: _____	Investigation complete date ___ / ___ / ___
Local health jurisdiction _____		Record complete date ___ / ___ / ___

Diphtheria: case defining variables are in **bold**. Answers are: Yes, No, Unknown to case, Not asked /Not answered