Tennessee Department of Health

Diphtheria Case Report

Draft, Revised: 04/2010

Please fill out all three pages of this form as complete as possible. Anything that appears in **red** is not available for data entry into NEDSS. However, you may find those fields helpful in your investigation. Do not forget to notify Central Office regarding this case.

DEMOGRAPHICS

CASE ID#:_____

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____

Reported Age: _____ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Phone - Home: _____ **Work:** _____ **Cell:** _____

Ethnicity: □ Hispanic □ Not Hispanic

Race: □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Other (_____)

Employer/School/Daycare: _____ **Occupation:** _____

ALTERNATE CONTACT INFORMATION

Last Name: _____ **First:**_____ **Relationship:** □ Parent □ Spouse □ Household Member □ Friend □ Other _____

Phone #:_____

INVESTIGATION SUMMARY

Jurisdiction: □ East Tennessee □ West Tennessee □ Jackson/Madison □ Mid-Cumberland □ Upper Cumberland □ Memphis/Shelby □ Northeast □ Nashville/Davidson □ Sullivan □ South Central □ Chattanooga/Hamilton □ Out of Tennessee □ Southeast □ Knoxville/Knox □ Unassigned

INVESTIGATION SUMMARY

Investigation Start Date: _____/_____/_____

Investigation Status: □ Open □ Closed

Investigator: _____

Date Assigned to Investigation: _____/_____/_____

Physician: _____

Physician's Phone: _____

REPORTING SOURCE

Date of Report: _____/_____/_____

Reporting Source: _____

Earliest Date Reported to County: _____/_____/_____

Earliest Date Reported to State: _____/_____/_____

Reporter: _____

CLINICAL INFORMATION

HOSPITAL INFORMATION

Was the patient hospitalized for this illness? □ Yes □ No □ Unknown

Hospital: _____

Admission Date:____/____/_____ **Discharge Date:** ____/____/_____

Illness Onset Dt:____/____/_____ **Illness End Dt:** ____/____/_____

Diagnosis Date:____/____/_____ **Age at onset?**_____

CONDITION

Is the patient pregnant? □ Yes □ No □ Unknown

Did the patient die from this illness? □ Yes □ No □ Unknown

SYMPTOMS

(Check all that apply)

□ **Stridor**
□ **Wheezing**
□ **Palatal weakness**
□ **Tachycardia**
□ **EKG abnormalities**
□ **Wheezing**
□ **Sore Throat**
□ **Difficulty in swallowing**
□ **Change in voice**
□ **Shortness of breath**
□ **Weakness**
□ **Fatigue**
□ **Fever (>100.5°F)**
Yes, highest temperature _____°F
□ **Other (**_____**)**

Soft tissue swelling (around membrane)**?**
□ Yes □ No

Neck edema? □ Yes □ No

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

Membrane Present?□ Yes □ No

If Yes, Sites
□ Tonsils
□ Soft Palate
□ Hard Palate
□ Larynx
□ Nares
□ Nasopharynx
□ Conjunctiva
□ Skin

COMPLICATIONS

□ **Airway Obstruction**
Onset Date_____/_____/_____

□ **Intubation required**

□ **Myocarditis**
Onset Date_____/_____/_____

□ **(Poly) neuritis**
Onset Date_____/_____/_____

□ **If other complications, specify**_____

LABORATORY

CASE ID#:_____

Was laboratory testing done for diphtheria? □ Yes □ No □ Unknown *(If yes, complete the table below.)*

	Throat Swab	Skin Ulcer Swab	Nasopharyngeal Swab	Other Site:
Was testing performed?	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	**Site?** _____
Name of Laboratory				
Date Specimen Taken				
Result of Test	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	
If Positive, Biotype?				

Serum Specimen for Diptheria Antitoxin Antibodies obtained? □ Yes □ No □ Unknown

If culture positive, results of toxigenicity testing? □ Not Done □ Positive □ Negative □ Unknown

Were the clinical specimens sent to CDC for genotyping (molecular typing)? □ Yes □ No □ Unknown

Date sent for genotyping: _____/_____/_____

Specimen Type:_____

VACCINATION

Did the patient receive diphtheria containing vaccine? □ Yes □ No □ Unknown

If No, reason (use number from choices): _____

1 - Born outside of US
2 - Laboratory evidence of previous disease
3 - MD diagnosis of previous disease
4 - Medical Contraindication
5 - Never offered vaccination
6 - Parent/Patient forgot to vaccinate
7 - Parent/Patient refusal
8 - Parent/Patient report of disease
9 - Philosophical objection
10 - Religious exemption
11 - Underage for vaccination
12 - Unknown

	Date	Type	Mfgr.	Lot #									
1	_____/_____/_____												
2	_____/_____/_____												
3	_____/_____/_____												
4	_____/_____/_____												
5	_____/_____/_____												
6	_____/_____/_____												

ANTIBIOTICS

Antibiotics given as an outpatient? □ Yes □ No □ Unknown

If yes, Name of antibiotic?_____ **(use number from choices)**

Date first antibiotic started? ____/____/_____

Number of days first antibiotic actually taken?_____

Antibiotics given as an outpatient? □ Yes □ No □ Unknown

If yes, Name of antibiotic?_____ **(use number from choices)**

Date first antibiotic started? ____/____/_____

Number of days first antibiotic actually taken?_____

Choices for antibiotics:

1 = Erythromycin (incl. pediazole, ilosone)
2 = Cotrimoxazole (bactrim/septra)
3 = Clarithromycin/Azithromycin
4 = Tetracycline/Doxycycline
5 = Amoxicillin/Penicillin/Ampicillin/Augmentin/Ceclor/Cefixime
6 = Other
9 = Unknown

Were antibiotics given in the 24 hours before culture? □ Yes □ No □ Unknown

EPIDEMIOLOGIC INFORMATION

Is this patient associated with a daycare facility?: □ Yes □ No □ Unknown

***If yes*, daycare:** _____

Is this case part of an outbreak?: □ Yes □ No □ Unknown

***If yes*, outbreak name:** _____

Where was the disease acquired?: □ Indigenous (within jurisdiction) □ Out of country □ Out of state □ Out of jurisdiction □ Unknown

Imported Country: _____

Imported State: _____

Imported City: _____

Imported County: _____

EPIDEMIOLOGIC INFORMATION (CONTINUED)

CASE ID#:_____

Length of time in the United States (in years): _____ **Country of birth:** _____

Has the patient had International or Interstate travel 2 weeks prior to onset?

INTERNATIONAL TRAVEL?

□ Yes □ No □ Unknown

***If yes*, where:** _____

Date left: ____/____/_____ **Date returned:** ____/____/_____

Did parotitis or other mumps-associated complication onset occur within 12-25 days of entering the USA, following any travel or living outside USA? (Import Status)

□ Yes □ No □ Unknown

INTERSTATE TRAVEL?

□ Yes □ No □ Unknown

***If yes*, where:** _____

Date left: ____/____/_____ **Date returned:** ____/____/_____

Known exposure to diphtheria case or carrier? □ Yes □ No □ Unknown **Known exposure to immigrants?** □ Yes □ No □ Unknown

Known exposure to international travelers? □ Yes □ No □ Unknown

CONTACT INFORMATION

Index Case Name:	**Index Case #:**

Contact Name	Date of Birth	Relationship To case	Date of exposure	# of Vaccines Doses	Date of Last Vaccine	Phone Number

Confirmation Method: □ Clinical Diagnosis □ Epidemiologically-linked □ Lab Confirmed □ Other (_____)

Case Status: □ Confirmed □ Suspect □ Probable

COMMENTS

_____

_____

_____

_____

FOR ADMINISTRATIVE USE ONLY:

Date of Interview: ____/____/_____

Interviewer's Name: _____

Other Notes: _____

Was the case entered into NEDSS? □ Yes □ No □ Unknown

Date entered into NEDSS: ____/____/_____

Data Entry Person's Name: _____