

DIPHTHERIA CASE REPORT

Patient name—last		first	middle initial	Date of birth	Age	Sex
Address—number, street			City	State	County	ZIP code
Telephone number						
Home ()			Work ()			
RACE (check one)					ETHNICITY (check one)	
<input type="checkbox"/> African-American/Black <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____					<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
If Asian/Pacific Islander, please check one:						
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Cambodian		<input type="checkbox"/> Chinese		<input type="checkbox"/> Filipino
<input type="checkbox"/> Japanese		<input type="checkbox"/> Korean		<input type="checkbox"/> Laotian		<input type="checkbox"/> Samoan
				<input type="checkbox"/> Vietnamese		<input type="checkbox"/> Other _____

PRESENT ILLNESS

Onset date (mm/dd/yy)	Diagnosis date (mm/dd/yy)	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Attending physician or consultant physician	Telephone number ()
Admit date (mm/dd/yy)	Discharge date (mm/dd/yy)	Medical record number	Hospital name	Telephone number ()
Brief clinical description (include nature and location of membrane, history of contact, probable source, etc.) (List household contacts in Remarks section.)				Outcome of case <input type="checkbox"/> Recovered <input type="checkbox"/> Sequelae <input type="checkbox"/> Died—Date: _____

HISTORY OF PREVIOUS IMMUNIZATION (Check one) Yes No

		Date Given	Dose	Type of Product (If known) (1) fluid toxoid OR (2) precipitated or adsorbed toxoid
Primary Immunization	First			
	Second			
	Third			
Boosters	First			
	Second			

Comments

THERAPY—SPECIFIC (Check one) Yes No

Antitoxin	Date	Hour	Units	Route of Administration	Manufacturer
First dose					
Second dose					
Third dose					

Therapeutic response: Prompt Delayed None

Other medical treatment (specify product)	Date of first dose	Date of second dose
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Name of attending physician	Address
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BASIS FOR DIAGNOSIS

Clinical only Laboratory tests Note: Positive cultures may be sent to the State Laboratory for virulence test and typing.

Type of Test	Date	Results	Name and Address of Laboratory
<input type="checkbox"/> Smear			
<input type="checkbox"/> Culture			
<input type="checkbox"/> Virulence			

PATIENT'S TRAVEL INFORMATION

Country of Residence

 United States Other, specify _____ .Date of U.S. arrival ____/____/____
MM DD YYHistory of **International** Travel (two weeks prior to the onset) Yes No Unknown If yes, please provide the following information:

Country(s) Visited	Month/Day/Year	Month/Day/Year
1.	From:	To:
2.	From:	To:
3.	From:	To:
4.	From:	To:
5.	From:	To:

History of **Interstate** Travel (two weeks prior to the onset) Yes No Unknown If yes, please provide the following information:

State(s) Visited	Month/Day/Year	Month/Day/Year
1.	From:	To:
2.	From:	To:
3.	From:	To:
4.	From:	To:
5.	From:	To:

Known exposure to Diphtheria cases or carrier? Yes No Unknown If yes, when _____ where _____Known exposure to international travelers? Yes No Unknown If yes, when _____ where _____Known exposure to immigrants? Yes No Unknown If yes, when _____ where _____**REMARKS** (Include comment if pertinent regarding occupation, economic status, environment, etc. Also note if other cases known in area or if this is single sporadic case.)

Investigator name (print)	Date	Telephone number ()
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Agency name

2010 CASE DEFINITION**CSTE Position Statement Number: 09-ID-05*****Diphtheria (Corynebacterium diphtheriae)*****Case classification:****Probable:**

In the absence of a more likely diagnosis, an upper respiratory tract illness with:

- an adherent membrane of the nose, pharynx, tonsils, or larynx; and
- absence of laboratory confirmation; and
- lack of epidemiologic linkage to a laboratory-confirmed case of diphtheria.

Confirmed:

An upper respiratory tract illness with an adherent membrane of the nose, pharynx, tonsils, or larynx; and any of the following:

- isolation of *Corynebacterium diphtheriae* from the nose or throat; or
- histopathologic diagnosis of diphtheria; or
- epidemiologic linkage to a laboratory-confirmed case of diphtheria.

Comment: Cutaneous diphtheria should not be reported