Diphtheria

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name: Suffix:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Disease Type ☐ Cutaneous ☐ Respiratory
Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness
Date of Death / /
Event exception ☐ Unknown ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other
Organism:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other
Organism:

Laboratory: _____ Accession #: _____ Collection date: / /

Date received: / / Specimen source: _____ Test type: _____

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: ☐ Other _____

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms (check all that apply):

☐ Bloody nasal discharge ☐ Fever ☐ Skin ulcers ☐ Stridor

☐ Draining ears ☐ Pharyngeal membrane ☐ Sore throat ☐ Swollen lymph nodes

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: _____

Date started: / /

Dose: _____

Unit: ☐ mg ☐ ml ☐ IU

# of days: _____ # of times a day: _____

Route: _____

Antibiotic: _____

Date started: / /

Dose: _____

Unit: ☐ mg ☐ ml ☐ IU

# of days: _____ # of times a day: _____

Route: _____

Antibiotic: _____

Date started: / /

Dose: _____

Unit: ☐ mg ☐ ml ☐ IU

# of days: _____ # of times a day: _____

Route: _____

Antitoxins prescribed? ☐ Yes ☐ No ☐ Unk

Date started: / /

Dose:

Unit: ☐ mg ☐ ml ☐ IU

# of days: # of times a day:

Route:

Therapeutic medications prescribed? ☐ Yes ☐ No ☐ Unk

List Medications:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.

EXPOSURE PERIOD

Average incubation period for **diphtheria** is 2-5 days; occasionally longer.

Onset

COMMUNICABLE PERIOD

Diphtheria is communicable for ~2 weeks or less. The rare chronic carrier may shed organisms for 6 months or more.

RISK FACTORS/TRAVEL

Vaccinated for diphtheria ☐ Yes ☐ No

Date vaccinated: / /

Lot #:

Vaccine type:

Manufacturer:

Date vaccinated: / /

Lot #:

Vaccine type:

Manufacturer:

Number of vaccinations: ____

In the 7 days prior to the onset of symptoms did the case:

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: — Departure date: / / — Return date: / /

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk — State: — City: — Departure date: / / — Return date: / /

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: — Departure date: / / — Return date: / /

Worked with a Case: ☐ Yes ☐ No ☐ Unk — From date: / / — To date: / /

Lived with another Case: ☐ Yes ☐ No ☐ Unk — From date: / / — To date: / /

Close contact with someone with similar symptoms: ☐Yes ☐No ☐ Unk

Treated for nasopharyngeal symptoms: ☐Yes ☐No ☐ Unk

CONTACTS

Number of people living in case's household: ____

Close contacts with similar symptoms

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse	☐ Sexual contact		/ /	☐ Yes
☐ Child	☐ Family member (non-household)			☐ No
☐ Sibling	☐ Friend/acquaintance			
☐ Roommate	☐ Contact- work/school/etc			
☐ Parent/ guardian	☐ Unknown/Other			

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse	☐ Sexual contact		/ /	☐ Yes
☐ Child	☐ Family member (non-household)			☐ No
☐ Sibling	☐ Friend/acquaintance			

☐ Roommate ☐ Contact- work/school/etc
☐ Parent/ guardian ☐ Unknown/Other

If this contact is a case create a new event and/or case for this contact.

Notes: _____