

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

Phone #: _____ ☐ Friend ☐ Other _____

INVESTIGATION SUMMARY

Jurisdiction: ☐ East Tennessee ☐ Mid-Cumberland ☐ Northeast ☐ South Central ☐ Southeast
☐ West Tennessee ☐ Upper Cumberland ☐ Nashville/Davidson ☐ Chattanooga/Hamilton ☐ Knoxville/Knox
☐ Jackson/Madison ☐ Memphis/Shelby ☐ Sullivan ☐ Out of Tennessee ☐ 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 ☐ Nares
☐ Soft Palate ☐ Nasopharynx
☐ Hard Palate ☐ Conjunctiva
☐ Larynx ☐ 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 Diphtheria 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

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

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

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

Date first antibiotic started? ____/____/____

Date first antibiotic started? ____/____/____

Number of days first antibiotic actually taken? _____

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

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

If yes, daycare: _____

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: _____

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 on-set 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: _____

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