

# CDC Diphtheria Worksheet

PATIENT INFORMATION	Date of Request <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>		Name (Last, First)					
	Birth Date <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>		Age <input type="text"/> <input type="text"/> <input type="text"/> <small>Unk = 999</small>	Age Type <input type="checkbox"/> 0 = 0-120 years <input type="checkbox"/> 1 = 0-11 months <input type="checkbox"/> 2 = 0-52 weeks <input type="checkbox"/> 3 = 0-28 days <input type="checkbox"/> 9 = Age unknown	Sex <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female <input type="checkbox"/> U = Unknown	Pregnant? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Race <input type="checkbox"/> N = Native Amer./Alaskan Native <input type="checkbox"/> A = Asian/Pacific Islander <input type="checkbox"/> B = African American <input type="checkbox"/> W = White <input type="checkbox"/> O = Other <input type="checkbox"/> U = Unknown	Ethnicity <input type="checkbox"/> H = Hispanic <input type="checkbox"/> N = Not Hispanic <input type="checkbox"/> U = Unknown
	Address (Street and No.)			County		State	Zip	Phone
	Date Symptom Onset <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>	Date First Diagnosis <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>	Date Hospitalized <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>	<b>History of Immunization Against Diphtheria</b> Childhood Primary Series? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		If < 18 Years Old, Number of Doses <input type="text"/>	Boosters as Adult? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Date of Last Dose <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> OR <input type="checkbox"/> U = Unk
Description of Clinical Picture							<b>Outcome</b> <input type="checkbox"/> N = Recovered, No Residua <input type="checkbox"/> R = Recovered, Residua <input type="checkbox"/> D = Died <input type="checkbox"/> U = Unknown	

CLINICAL INFORMATION	<i>Enter Y = Yes, N = No, or U = Unknown in the Boxes Below Unless Otherwise Indicated</i>						
	<b>Symptoms</b> Fever? <input type="checkbox"/> Sore Throat? <input type="checkbox"/> Difficulty Swallowing? <input type="checkbox"/> Change in Voice? <input type="checkbox"/> Shortness of Breath? <input type="checkbox"/> Weakness? <input type="checkbox"/> Fatigue? <input type="checkbox"/> Other? <input type="checkbox"/>		<b>Signs</b> Fever? <input type="checkbox"/> If Yes, Temp <input type="text"/> <input type="text"/> <input type="text"/> °C Membrane? <input type="checkbox"/> If Yes, Site(s) <input type="text"/> Tonsils <input type="checkbox"/> Soft Palate <input type="checkbox"/> Hard Palate <input type="checkbox"/> Larynx <input type="checkbox"/> Nares <input type="checkbox"/> Nasopharynx <input type="checkbox"/> Conjunctiva <input type="checkbox"/> Skin <input type="checkbox"/>		<b>Soft Tissue Swelling?</b> <input type="checkbox"/> <small>(Around Membrane)</small> Neck Edema? <input type="checkbox"/> If Yes <input type="checkbox"/> B = Bilateral <input type="checkbox"/> L = Left Side Only <input type="checkbox"/> R = Right Side Only If Yes, Extent <input type="checkbox"/> S = Submandibular Only <input type="checkbox"/> M = Midway to Clavicle <input type="checkbox"/> C = To Clavicle <input type="checkbox"/> B = Below Clavicle Stridor? <input type="checkbox"/> Wheezing? <input type="checkbox"/> Palatal Weakness? <input type="checkbox"/> Tachycardia? <input type="checkbox"/> EKG Abnormalities? <input type="checkbox"/>		<b>Complications</b> Complications? <input type="checkbox"/> Airway Obstruction? <input type="checkbox"/> Date of Onset <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> Intubation Required? <input type="checkbox"/> Myocarditis? <input type="checkbox"/> Date of Onset <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> (Poly)neuritis? <input type="checkbox"/> Date of Onset <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> Other? <input type="checkbox"/> Describe:

LABORATORY	Specimen for Diphtheria Culture Obtained? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	If Yes, Obtained on <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="checkbox"/> U = Unknown <small>Month Day Year</small>	Culture Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> U = Unknown	Specify Lab Performing Culture:	If Culture Positive, Biotype <input type="checkbox"/> M = Mitis <input type="checkbox"/> G = Gravis <input type="checkbox"/> I = Intermedius <input type="checkbox"/> B = Belfanti
	If Culture Positive, Results of Toxicogenicity Testing <input type="checkbox"/> X = Not Done <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> U = Unknown	Specimen Sent to CDC Diphtheria Lab for Confirmation/Molecular Typing? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> W = Will be Sent	Type of Specimen (Check All That Apply) <input type="checkbox"/> Clinical Swab <input type="checkbox"/> Piece of Membrane <input type="checkbox"/> C. diphtheria Isolate	Serum Specimen for Diphtheria Antitoxin Antibodies Obtained? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> W = Will be Obtained Prior to DAT	PCR Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> U = Unknown <input type="checkbox"/> X = Not Done

ANTIBIOTICS	Treated with Antibiotics? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No	As an Outpatient If Yes, Date Initiated <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>	Antibiotic <input type="checkbox"/> See Codes Below	Duration of Therapy <input type="text"/> <input type="text"/> <small>Days</small>	Antibiotic Therapy in Hospital? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No	As an Inpatient If Yes, Date Initiated <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>	Antibiotic <input type="checkbox"/> See Codes Below	Duration of Therapy <input type="text"/> <input type="text"/> <small>Days</small>
	Were Antibiotics Given in the 24 Hours Before Culture? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	1 = Erythromycin (Incl. Pediazole, Ilosone)	5 = Cotrimoxazole (Bactrim/Septra)	2 = Penicillin (Bicillin, Pfizerpen-AS, Wycillin)	6 = Tetracycline/Doxycycline	3 = Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixime	7 = Other	4 = Clarithromycin/azithromycin

Note: This Form Has 2 Sides

EXPOSURE	<b>Country of Residence</b> <input type="checkbox"/> U = US <input type="checkbox"/> O = Other		<b>If Other, Country Name:</b> _____		<b>Date of US Arrival</b> <input type="text"/> <input type="text"/> <input type="text"/> <b>OR</b> <input type="checkbox"/> <small>Month Day Year U = Unknown</small>																													
	<b>History of International Travel?</b> (2 Weeks Prior to Onset) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	<b>Country(s) Visited</b> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">From</th> <th colspan="3">To</th> </tr> <tr> <th>Month</th> <th>Day</th> <th>Year</th> <th>Month</th> <th>Day</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> <tr> <td>_____</td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </tbody> </table>							From			To			Month	Day	Year	Month	Day	Year	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<b>Known Exposure to Diphtheria Case or Carrier?</b> <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	<b>Known Exposure to International Travelers?</b> <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<b>Known Exposure to Immigrants?</b> <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown																															

REPORTING INFORMATION	<b>Has This Suspected Case Been Reported to The State or Local Health Department?</b> <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		<b>Date Reported to State or Local Health Department</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>			
	<b>Person Informed:</b> _____		<b>Phone</b> <input type="text"/> - <input type="text"/> - <input type="text"/>		<b>Fax</b> <input type="text"/> - <input type="text"/> - <input type="text"/>	
	<b>Reporting Physician:</b> _____		<b>Phone</b> <input type="text"/> - <input type="text"/> - <input type="text"/>		<b>Fax</b> <input type="text"/> - <input type="text"/> - <input type="text"/>	

REQUESTING PHYSICIAN	<b>Name</b>					
	<b>Institution</b>					
	<b>Street</b>					
	<b>City</b>				<b>State</b>	<b>Zip</b>
	<b>Phone</b> <input type="text"/> - <input type="text"/> - <input type="text"/>			<b>Fax</b> <input type="text"/> - <input type="text"/> - <input type="text"/>		
	<b>Name of Investigator Under the IND (If Different From Requesting Physician)</b>			<b>Phone</b> <input type="text"/> - <input type="text"/> - <input type="text"/>		<b>Fax</b> <input type="text"/> - <input type="text"/> - <input type="text"/>

SEND DRUG TO	<b>Name</b>					
	<b>Attn.</b>					
	<b>Institution</b>					
	<b>Street</b>					
	<b>City</b>				<b>State</b>	<b>Zip</b>
	<b>Phone</b> <input type="text"/> - <input type="text"/> - <input type="text"/>			<b>Fax</b> <input type="text"/> - <input type="text"/> - <input type="text"/>		

DOSE	<b>Amount of DAT Administered:</b> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> IU DAT					
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DISPOSITION	<b>Final Diagnosis:</b> _____		<b>How Was the Final Diagnosis Confirmed?</b> _____		<b>Final Case Disposition</b> <input type="checkbox"/> C = Confirmed <input type="checkbox"/> P = Probable <input type="checkbox"/> N = Not a Case	
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This document can be found on the CDC website at:  
<http://www.cdc.gov/diphtheria/downloads/dip-wksht.pdf>