

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>	History of Immunization Against Diphtheria 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="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <small>Month Day Year</small> OR <input type="checkbox"/> U = Unk
Description of Clinical Picture							Outcome <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>						
	Symptoms 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"/>		Signs 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"/>		Signs Soft Tissue Swelling? <input type="checkbox"/> (Around Membrane) 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"/>		Complications 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)	2 = Penicillin (Bicillin, Pfizerpen-AS, Wycillin)	3 = Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixime	4 = Clarithromycin/azithromycin	5 = Cotrimoxazole (Bactrim/Septra)	6 = Tetracycline/Doxycycline	7 = Other

EXPOSURE	Country of Residence <input type="checkbox"/> U = US <input type="checkbox"/> O = Other		If Other, Country Name: _____		Date of US Arrival <input type="text"/> <input type="text"/> <input type="text"/> OR <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year U = Unknown</small>																														
	History of International Travel? (2 Weeks Prior to Onset) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Country(s) Visited <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;"></th> <th colspan="3">From</th> <th colspan="3">To</th> </tr> <tr> <th></th> <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"/>
		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"/>																													
History of Interstate Travel? (2 Weeks Prior to Onset) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		State(s) Visited <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;"></th> <th colspan="3">From</th> <th colspan="3">To</th> </tr> <tr> <th></th> <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"/>	
	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"/>																													
Known Exposure to Diphtheria Case or Carrier? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Known Exposure to International Travelers? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Known Exposure to Immigrants? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown																															

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

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

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

DOSE	Amount of DAT Administered: <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> IU DAT					
------	---	--	--	--	--	--

DISPOSITION	Final Diagnosis: _____		How Was the Final Diagnosis Confirmed? _____		Final Case Disposition <input type="checkbox"/> C = Confirmed <input type="checkbox"/> P = Probable <input type="checkbox"/> N = Not a Case	
-------------	-------------------------------	--	---	--	---	--

--