U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

DIPHTHERIA SURVEILLANCE WORKSHEET

To be completed by requesting/treating clinician and returned to CDC within 14 days of DAT/S315 administration

PATIENT INFORMATION

Date of Request *(mm/dd/yyyy)* | **Name** *(Last, First)* | **Phone**

Address *(Street and No.)* | **County** | **State** | **Zip**

Birth Date *(mm/dd/yyyy)* | **Age** *Unknown=999*

Age Type
- ○ 0–120 years
- ○ 0–11 months
- ○ 0–52 weeks
- ○ 0–28 days
- ○ Age unknown

Sex
- ○ Male
- ○ Female

Pregnant
- ○ Yes
- ○ No
- ○ Unknown

Race
- ○ Native Amer./Alaskan Native
- ○ Asian/Pacific Islander
- ○ Black/African American
- ○ White
- ○ Other
- ○ Multiracial
- ○ Unknown

Ethnicity
- ○ Hispanic/Latino
- ○ Not Hispanic/Not Latino
- ○ Unknown

CLINICAL INFOMATION

Date of Symptom Onset *(mm/dd/yyyy)* | **Date First Diagnosis** *(mm/dd/yyyy)* | **Date Hospitalized** *(mm/dd/yyyy)*

History of Immunization Against Diphtheria

Childhood primary series?
- ○ *Yes*
- ○ *No*
- ○ *Unknown*

If >18 years old, number of doses

Boosters as an adult?
- ○ *Yes*
- ○ *No*
- ○ *Unknown*

Date of last dose? *(mm/dd/yyyy)*
- ○ *Unknown*

Description of Clinical Picture:

SYMPTOMS
- ☐ **Fever**
- ☐ **Sore Throat**
- ☐ **Difficulty Swallowing**
- ☐ **Change in Voice**
- ☐ **Shortness of Breath**
- ☐ **Weakness**
- ☐ **Fatigue**
- ☐ **Other**

SIGNS
- ☐ **Fever** *if Yes, Temp* _____ *°C*
- ☐ **Membrane?** *if Yes, sites:*
  - ☐ Tonsils ☐ Soft palate ☐ Hard palate ☐ Larynx
  - ☐ Nares ☐ Nasopharynx ☐ Conjunctiva ☐ Skin
- ☐ **Soft Tissue Swelling** *(around membrane)?*
- ☐ **Neck Edema?** *if Yes, sites:*
  - ☐ Bilateral ☐ Left Side Only ☐ Right Side Only
  - if Yes, extent:
    - ☐ Submandibular ☐ Midway to clavicle
    - ☐ To clavicle ☐ Below clavicle
- ☐ **Stridor** ☐ **Wheezing**
- ☐ **Palatal Weakness** ☐ **Tachycardia**
- ☐ **EKG Abnormalities?** *if Yes, describe below:*

COMPLICATIONS
- ☐ **Complications?**
- ☐ **Airway Obstruction?** *Onset Date (mm/dd/yyyy)*
- ☐ **Inubation Required?**
- ☐ **Myocarditis?** *Onset Date (mm/dd/yyyy)*
- ☐ **Poly(neuritis)?** *Onset Date (mm/dd/yyyy)*
- ☐ **Other:** *Onset Date (mm/dd/yyyy)*

ANTIBIOTICS

Outpatient treatment with antibiotics?
- ○ Yes
- ○ No
- ○ Unknown

If Yes, date outpatient treatment initiated *(mm/dd/yyyy)*

Antibiotic initiated *(see codes below)*

Therapy duration *(days)*

Antibiotic therapy in hospital?
- ○ Yes
- ○ No
- ○ Unknown

If Yes, date inpatient treatment initiated *(mm/dd/yyyy)*

Antibiotic initiated *(see codes below)*

Therapy duration *(days)*

Were antibiotics given in the 24 hours before specimen collection?
- ○ Yes
- ○ No
- ○ Unknown

Antibiotic Codes

1 = Erythromycin (incl. Pediazole, Ilosone) or other fluoroquinolone)
2 = Penicillin (penicillin G, penicillin V K)
3 = Tetracycline, doxycycline (or other tetracycline)
4 = Amoxicillin/Augmentin/ampicillin (or other aminopenicillin)
5 = Azithromycin (or other macrolide)
6 = Trimethoprim/sulfamethoxazole
7 = Ciprofloxacin, levofloxacin
8 = Cephalexin, ceftriaxone (or other cephalosporin)
9 = Vancomycin
10 = Other (specify) _____
11 = Unknown

EXPOSURE

Country of Residence
◯ US
◯ Other

If Other, country name: _____

Date of US arrival _____ **or** ◯ Unknown
(mm/dd/yyyy)

History of International Travel?
(2 Weeks Prior to Onset)
◯ Yes
◯ No
◯ Unknown

Country visited: _____ **to** _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

Country visited: _____ **to** _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

History of Interstate Travel?
(2 Weeks Prior to Onset)
◯ Yes
◯ No
◯ Unknown

State visited: _____ **to** _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

State visited: _____ **to** _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

History of *(select all that apply)***?**
☐ Homelessness
☐ Unstable housing
☐ IV drug use
☐ None
☐ Unknown

Known exposure to *(select all that apply)*
☐ Dogs
☐ Cats
☐ Unpasteurized dairy
☐ Farm animals
☐ None
☐ Unknown

Known exposure to diphtheria case or carrier?
◯ Yes
◯ No
◯ Unknown

LABORATORY

Specimen for culture obtained?
◯ Yes
◯ No
◯ Unknown

If yes, date specimen obtained? *(mm/dd/yyyy)*
_____ **or** ◯ Unknown

Type of specimen *(check all that apply)***?**
☐ Clinical swab
☐ Tissue
☐ Piece of pseudomembrane
☐ Blood
☐ Fluid
☐ Other: _____

Culture results if done?
◯ Positive
◯ Negative
◯ Unknown

Performing Laboratory *(for culture)*

If positive, culture results
◯ *C. diphtheriae*
◯ *C. ulcerans*
◯ *C. pseudotuberculosis*

Culture result confirmed by?
◯ MALDI-TOF
◯ Biochemical testing

PCR Result
◯ *Tox* bearing
◯ *C. diphtheriae*
◯ *C. ulcerans*/*C. pseudotuberculosis*
◯ Not done
◯ Negative
◯ Unknown

REPORTING

Has this suspected case been reported to the State or Local Health Department?
◯ Yes ◯ No ◯ Unknown

Date reported to State or Local Health Department: _____
(mm/dd/yyyy)

Health Department person Informed: _____

Phone _____ **Fax** _____ **Title** _____

REQUESTING PHYSICIAN

Name: _____

Institution: _____

Address: _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____ **Email** _____

Name of Investigator Under the Investigational New Drug Protocol (IND) *(if different from requesting physician)***:** _____

Phone _____ **Fax** _____

SEND DAT TO

Name: _____

Institution: _____

Address: _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____ **Email** _____

DOSE

Amount of DAT/S315 Administered: _____ **Date administered:** _____

Adverse Event Reported?
◯ Yes ◯ No ◯ Unknown

DISPOSITION

Final Diagnosis:

Final Diagnosis Confirmed By?

Final Case Disposition
◯ Confirmed
◯ Suspect
◯ Not a Case/Carrier
◯ Carrier

Outcome
◯ Recovered
◯ Deceased
◯ Unknown