Washington State Department of Health

Diphtheria

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____

LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification ☐ Classification pending ☐ Confirmed
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status
☐ In progress
☐ Complete
☐ Complete – not reportable to DOH
☐ Unable to complete Reason _____

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

Employed ☐ Yes ☐ No ☐ Unk Occupation _____
Industry _____ Employer _____
Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk
Type of school ☐ Preschool/day care ☐ K-12 ☐ College
☐ Graduate School ☐ Vocational ☐ Online ☐ Other
School name _____
School address _____
City/State/County _____ Zip _____
Phone number _____ Teacher's name _____

REPORT SOURCE

Initial report source _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

COMMUNICATIONS

Primary HCP name _____
Phone _____

OK to talk to patient (If Later, provide date)
☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___
☐ Complete ☐ Partial ☐ Unable to reach

☐ Patient could not be interviewed

Alternate contact ☐ Parent/Guardian ☐ Spouse/Partner
☐ Friend ☐ Other _____
Name _____ Phone _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___
Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Clinical Features

Y	N	Unk	
☐	☐	☐	**Any fever, subjective or measured** Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**Pharyngitis (sore throat)**
☐	☐	☐	**Adherent pseudo-membrane of the nose, pharynx, tonsil(s), or larynx**
☐	☐	☐	Stridor Onset date ___/___/___
☐	☐	☐	Myocarditis Onset date ___/___/___
☐	☐	☐	Bloody nasal discharge
☐	☐	☐	Cervical lymph node enlargement (bull neck)
☐	☐	☐	Acute respiratory illness
☐	☐	☐	Dyspnea (shortness of breath)
☐	☐	☐	Skin lesions/cutaneous
☐	☐	☐	Other symptoms consistent with this illness _____

Vaccination

Y	N	Unk	
☐	☐	☐	Ever received diphtheria containing vaccine Number of diphtheria doses prior to illness _____

Diphtheria required variables are in **bold.** Answers are: Yes, No, Unknown to case

Case Name ______________________ LHJ Case ID ______________________

Vaccine information available ☐ Yes ☐ No

Date of vaccine administration ___/___/___ Vaccine administered (Type) ______________________
Vaccine lot number ______________________ Administering provider ______________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ______________________
Vaccine lot number ______________________ Administering provider ______________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
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☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Y N Unk

☐ ☐ ☐ Diphtheria vaccination up to date for age per ACIP
Vaccine series not up to date reason
☐ Religious exemption ☐ Medical contraindication ☐ Philosophical exemption
☐ Laboratory confirmation of previous disease ☐ MD diagnosis of previous disease
☐ Underage for vaccine ☐ Parental refusal ☐ Other ☐ Unknown

Hospitalization

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ______________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ______________________
☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk

☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition
Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital) ☐ Emergency department (ED)
☐ Inpatient ward ☐ ICU ☐ Other ______________________

RISK AND RESPONSE (Ask about exposures 1-10 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ Other ________	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ Other ________	☐ County/City ________ ☐ State ________ ☐ Country ________ ☐ Other ________
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country ______________________
☐ ☐ ☐ Contact with recent foreign arrival Country ______________________
☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter
☐ Other ______________________

☐ ☐ ☐ Health care worker

Y N Unk

☐ ☐ ☐ Unpasteurized milk (cow)
☐ ☐ ☐ Other unpasteurized dairy products (e.g., soft cheese from raw milk, queso fresco or food made with these cheeses)
☐ ☐ ☐ Other unpasteurized milk (e.g. sheep, goat) Specify _____
☐ ☐ ☐ Known exposure to a Diphtheria carrier Exposure circumstances, age of carrier _____

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ **Epidemiologically linked to a lab positive case classified as confirmed**

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____
☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Foodborne ☐ Person to person ☐ Health care associated ☐ Unk
☐ Other _____
Describe _____

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship
☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit
☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Exposure summary

Suspected transmission type (check all that apply) ☐ Person to person ☐ Health care associated ☐ Unk
☐ Other _____
Describe _____

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Public Health Issues

Y N Unk

☐ ☐ ☐ Employed as health care worker
☐ ☐ ☐ Household member or close contact in sensitive occupation or setting (HCW, childcare, food)
☐ ☐ ☐ Face to face contact with newborns, unimmunized children, women > 7 months pregnant or others at risk for severe complications

Evaluated immune status of close contacts ☐ Yes Date initiated ___/___/___
Number of close contacts evaluated for immune status _____
Number of susceptible contacts identified _____
☐ No, close contacts not evaluated
☐ No, case had no close contacts
☐ Unk

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Strict respiratory isolation until 48 hours of treatment completed or for 14 days
☐ ☐ ☐ Surveillance cultures of appropriate contacts
☐ ☐ ☐ Prophylaxis of appropriate contacts recommended Date initiated ___/___/___
Number of contacts recommended prophylaxis _____
Number of contacts receiving prophylaxis _____
Number of contacts completing prophylaxis _____
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

Contagious period: 14 days from symptom onset date

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk

Settings and details (check all that apply)

☐ Day care ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Health care ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

Case Name _____ LHJ Case ID _____

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

☐ ☐ ☐ Did patient receive prophylaxis/treatment

Specify medication _____ ☐ Antibiotic ☐ Immune globulin/Antitoxin

☐ Other _____

Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___

Prescribed dose _____ ☐ g ☐ mg ☐ ml Frequency _____ Duration _____ ☐ Days ☐ Weeks ☐ Months

Indication ☐ PEP ☐ Treatment for disease ☐ Incidental ☐ Other _____

Did patient take medication as prescribed ☐ Yes ☐ No - Why not _____ ☐ Unk

Prescribing provider _____

NOTES

LAB RESULTS

Lab report information

Lab report reviewed – LHJ ☐

WDRS user-entered lab report note

Submitter _____

Performing lab for entire report_____

Referring lab _____

Specimen

Specimen identifier/accession number _____

Specimen collection date ___/___/___ Specimen received date ___/___/___

WDRS specimen type _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result

WDRS test performed _____

WDRS test result, coded _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending

Test result status ☐ Final results; Can only be changed with a corrected result

☐ Preliminary results

☐ Record coming over is a correction and thus replaces a final result

☐ Results cannot be obtained for this observation

☐ Specimen in lab; results pending

Result date ___/___/___

Upload document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____