CONFIDENTIAL COMMUNICABLE DISEASE REPORT—PART 2

DIPHTHERIA

Name of laboratory:

Virulence:

Results:

Culture:

AUGUST 2011

NC EDSS EVENT ID#

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

NC EDSS LAB RESULTS

Verify if lab results for this event are in NC EDSS. If not present, enter results.

BACTERIOLOGICAL RESULTS OF NOSE AND THROAT CULTURES FROM PATIENT

<table>
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<tr>
<th>Date collected</th>
<th>Results</th>
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RELEASE SPECIMENS

|               |         |               |         |                    |

NC EDSS PART 2 WIZARD

COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U

If yes, symptom onset date (mm/dd/yyyy): __/__/____

CHECK ALL THAT APPLY:

Fever Y N U

Yes, subjective Y N U

Yes, measured Y N U

Highest measured temperature ____________

Fever onset date (mm/dd/yyyy): __/__/____

Fatigue or malaise or weakness Y N U

Cranial nerve or bulbar weakness Y N U

or paralysis Y N U

Please specify:

Difficulty swallowing (dysphagia) Y N U

Polyneuritis Y N U

Onset date (mm/dd/yyyy): __/__/____

Change in voice Y N U

Sore throat Y N U

Diphtheria membrane present Y N U

Site(s) (check all that apply):

Tonsils Y N U

Soft palate Y N U

Hard palate Y N U

Larynx Y N U

Nares Y N U

Nasopharynx Y N U

Conjunctiva Y N U

Skin Y N U

Unknown Y N U

Soft tissue swelling around membrane Y N U

Neck edema Y N U

Sides Y N U

Right Y N U

Left Y N U

Bilateral Y N U

Unknown Y N U

Extent Y N U

Submandibular only Y N U

Below clavicle Y N U

Midway to clavicle Y N U

To clavicle Y N U

Airway obstruction Y N U

Onset date (mm/dd/yyyy): __/__/____

Intubation required Y N U

Palatal weakness Y N U

Respiratory arrest Y N U

Wheezing Y N U

Stridor Y N U

Shortness of breath/difficulty breathing/ respiratory distress Y N U

Tachycardia Y N U

Myocarditis Y N U

Onset date (mm/dd/yyyy): __/__/____

EKG obtained Y N U

Abnormal? Y N U

Other symptoms, signs, clinical findings, or complications consistent with this illness? Y N U

If yes, specify:

Any immunosuppressive conditions? Y N U

Specify _________________________________

TREATMENT

Did patient take an antibiotic as treatment for this illness? Y N U

If yes, specify antibiotic name _________________________________

Dose _________________________________

Administration route: Y N U

Oral Y N U

Topical Y N U

Intravenous (IV) Y N U

Intramuscular (IM) Y N U

Other Y N U

Specify route: Y N U

Intravenous (IV) Y N U

Intramuscular (IM) Y N U

Other Y N U

Specify amount of DAT administered (IU DAT) Y N U

Date received: _________________________________

Was diphtheria antitoxin (DAT) given? Y N U

Date antibiotic began__________________________

Date antibiotic ended__________________________

Were antibiotics given in the 24 hours before culture? Y N U

Hospital contact name: _________________________________

City, State: _________________________________

TelephoneNumber: _________________________________

Admit date (mm/dd/yyyy): __/__/____

Discharge date (mm/dd/yyyy): __/__/____

(CONTINUED)
### CLINICAL OUTCOMES

- **Survived?** [ ] Y [ ] N [ ] U
  - Status at time of report:
    - [ ] Fully recovered
    - [ ] Survived but experiencing sequelae (residual deficit from illness) at time of report

- **Died?** [ ] Y [ ] N [ ] U
  - **Died from this illness?** [ ] Y [ ] N [ ] U
  - Date of death (mm/dd/yyyy): 
    - Patient died in North Carolina? [ ] Y [ ] N [ ] U
    - County of death: 
    - Died outside NC? [ ] Y [ ] N [ ] U
    - Specify where: 
    - Autopsy performed? [ ] Y [ ] N [ ] U
    - Facility where autopsy was performed: 

- Patient autopsied in NC? [ ] Y [ ] N [ ] U
- Autopsied outside NC, specify where:
- Source of death information: (select all that apply):
  - [ ] Death certificate
  - [ ] Autopsy report
  - [ ] Hospital/physician discharge summary
  - [ ] Other:

- Cause of death: 

- **Autopsy report final conclusions**:
- County of autopsy: 
- Facility where autopsy was performed: 

### TRAVEL

- **The patient is:**
  - [ ] Resident of North Carolina
  - [ ] Resident of another state or US territory
  - [ ] Foreign visitor
  - [ ] Refugee
  - Refugee camp(s)? [ ] Y [ ] N [ ] U
  - Location of camp: 
  - Country of birth: 
  - Last country prior to arrival in US: 
  - Date of entry to US: 
  - [ ] Recent immigrant
  - Country of birth: 
  - Last country prior to arrival in US: 
  - Date of entry to US: 
  - [ ] Foreign adoptee
  - Country of birth: 
  - Last country prior to arrival in US: 
  - Date of entry to US: 
  - [ ] None of the above

### RISKS

During the 10 days prior to onset until 2 days after onset of symptoms, did the patient have any contact with:
- [ ] Domestic pets
- [ ] Horses
- [ ] Dairy farm animals

If yes, did any of the animals have lesions on their skin? [ ] Y [ ] N [ ] U

- Notes:

### VACCINE

- Has patient / contact ever received diphtheria-containing vaccine? [ ] Y [ ] N [ ] U

Vaccine #1:
- **Date of vaccination** (mm/dd/yyyy): 
  - [ ] Y [ ] N [ ] U
  - Vaccine type: 
  - Manufacturer: 
  - Product/trade name: 
  - Lot number: 

Vaccine #2:
- **Date of vaccination** (mm/dd/yyyy): 
  - [ ] Y [ ] N [ ] U
  - Vaccine type: 
  - Manufacturer: 
  - Product/trade name: 
  - Lot number: 

Vaccine #3:
- **Date of vaccination** (mm/dd/yyyy): 
  - [ ] Y [ ] N [ ] U
  - Vaccine type: 
  - Manufacturer: 
  - Product/trade name: 
  - Lot number: 

Vaccine #4:
- **Date of vaccination** (mm/dd/yyyy): 
  - [ ] Y [ ] N [ ] U
  - Vaccine type: 
  - Manufacturer: 
  - Product/trade name: 
  - Lot number: 

Vaccine #5:
- **Date of vaccination** (mm/dd/yyyy): 
  - [ ] Y [ ] N [ ] U
  - Vaccine type: 
  - Manufacturer: 
  - Product/trade name: 
  - Lot number: 

- **Source of vaccine information:**
  - [ ] Patient's or Parent's verbal report
  - [ ] Medical record
  - [ ] Medical record (Note: Any vaccine on a medical record should be recorded in the NCIR)
  - [ ] Certificate of immunization record (Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)
  - [ ] Other:

- **Number of doses received prior to illness:** 

- **Date of last diphtheria-containing vaccine prior to onset of illness:** (mm/dd/yyyy): 
  - [ ] Y [ ] N [ ] U

- Did patient receive a booster dose as an adult? [ ] Y [ ] N [ ] U

- **Date of last booster received** (mm/dd/yyyy): 
  - [ ] Y [ ] N [ ] U

- **Reasons:**
  - [ ] Missed opportunities
  - [ ] Other:

- **Other:**

---

**Patient's Last Name**

**First Name**

**Middle Name**

**Suffix**

**Maiden/Other Name**

**Alias**

**Birthdate** (mm/dd/yyyy)

**SSN**
**PREGNANCY**

- **Is the patient currently pregnant?** _[ ] Y  _[ ] N  _[ ] U_
  - _Estimated delivery date (mm/dd/yyyy):__/__/____
  - _Give number of weeks gestation at onset of illness:_

- **Has the mother received prenatal care?** _[ ] Y  _[ ] N  _[ ] U_
  - _Date of first prenatal visit (mm/dd/yyyy):__/__/___
  - _Number of prenatal visits:_

- **Prenatal provider name:** ____________________________
  - _OB Name:_
  - _Street address:_
  - _City:_
  - _State:_
  - _Zip code:_
  - _Phone (__________)_

- **Has the patient ever been pregnant?** _[ ] Y  _[ ] N  _[ ] U_
  - _Total number of previous pregnancies of the biologic mother:_

**TREATMENT**

- **Did the patient take an antibiotic as prophylaxis secondary to being a contact of a confirmed case?** _[ ] Y  _[ ] N  _[ ] U_
  - _If yes, specify antibiotic name:_

- **Was patient treated for nasopharyngeal carriage?** _[ ] Y  _[ ] N  _[ ] U_

- **Has this contact received immune globulin?** _[ ] Y  _[ ] N  _[ ] U_
  - _Date received (mm/dd/yyyy):__/__/___

- **Did the patient require mechanical ventilation?** _[ ] Y  _[ ] N  _[ ] U_
  - _Date started (mm/dd/yyyy):__/__/___
  - _Number of days on mechanical ventilation:_

**TRAVEL/IMMIGRATION**

- **Was pregnant woman while traveling?** _[ ] Y  _[ ] N  _[ ] U_
  - _Does patient know anyone else with similar symptom(s) who had the same or similar travel history?_ _[ ] Y  _[ ] N  _[ ] U_

  - _Name:_

**CLINICAL OUTCOMES**

- **Discharge/Final diagnosis:** ________________________________

- **PREDISPOSING CONDITIONS**

  - **Other underlying illness** _[ ] Y  _[ ] N  _[ ] U_

  - _Please specify:_

  - **Was the patient receiving any of the following treatments or taking any medications?**
    - _For what medical condition?_
    - _If yes, was therapy within the last 30 days before this illness?_ _[ ] Y  _[ ] N  _[ ] U_
    - _For what medical condition?_
    - _If yes, was therapy within the last 30 days before this illness?_ _[ ] Y  _[ ] N  _[ ] U_
    - _For what medical condition?_
    - _Systemic steroids/oral corticosteroids, including steroids taken by mouth or injection_ _[ ] Y  _[ ] N  _[ ] U_
    - _If yes, was medication taken within the last 30 days before this illness?_ _[ ] Y  _[ ] N  _[ ] U_
    - _For what medical condition?_
    - _Immunosuppressive therapy, including anti-rejection therapy_ _[ ] Y  _[ ] N  _[ ] U_
    - _If yes, specify:_
    - _Systemic steroids/oral corticosteroids, including steroids taken by mouth or injection_ _[ ] Y  _[ ] N  _[ ] U_
    - _If yes, was medication taken within the last 30 days before this illness?_ _[ ] Y  _[ ] N  _[ ] U_
    - _For what medical condition?_
    - _Aspirin or aspirin-containing product_ _[ ] Y  _[ ] N  _[ ] U_
    - _If yes, was medication taken within the last 30 days before this illness?_ _[ ] Y  _[ ] N  _[ ] U_
    - _For what medical condition?_

**REASON FOR TESTING**

- **Why was the patient tested for this condition?**
  - _Symptomatic of disease_
  - _Screening of asymptomatic person with reported risk factor(s)_
  - _Exposed to organism causing this disease (asymptomatic)_
  - _Household / close contact to a person reported with this disease_
  - _Other, specify:_
  - _Unknown_

**ISOLATION/QUARANTINE/CONTROL MEASURES**

- **Restrictions to movement or freedom of action?** _[ ] Y  _[ ] N_
  - _Check all that apply:_
    - _Work_ _[ ] Y  _[ ] N_
    - _Sexual behavior_ _[ ] Y  _[ ] N_
    - _School_ _[ ] Y  _[ ] N_
    - _Other, specify:_ _[ ] Y  _[ ] N_

  - _Date control measures issued:_
  - _Date control measures ended:_

  - **Was patient compliant with control measures?** _[ ] Y  _[ ] N_

  - **Local health director or designee implement additional control measures?** (example: cohort classrooms, special cleaning, active surveillance, etc.) _[ ] Y  _[ ] N_
  - _If yes, specify:_ _[ ] Y  _[ ] N_

  - **Were written isolation orders issued?** _[ ] Y  _[ ] N_
    - _If yes, where was the patient isolated?_
    - _Date isolation started:_
    - _Date isolation ended:_

  - **Were written quarantine orders issued?** _[ ] Y  _[ ] N_
    - _If yes, where was the patient quarantined?_
    - _Date quarantine started:_
    - _Date quarantine ended:_

  - **Was the patient compliant with quarantine?** _[ ] Y  _[ ] N_

**CHILD/CARE/SCHOOL/COLLEGE**

  - _Name of care provider:_
  - _Address:_
  - _City:_
  - _State:_
  - _Zip code:_
  - _Contact name:_
  - _Telephone:_

**Patient a a student?** _[ ] Y  _[ ] N  _[ ] U_
  - _Name:_
  - _Address:_
  - _City:_
  - _State:_
  - _Zip code:_
  - _Contact name:_
  - _Telephone:_

**Is patient a school WORKER / VOLUNTEER in NC school setting?** _[ ] Y  _[ ] N  _[ ] U_
  - _Name:_
  - _Address:_
  - _City:_
  - _State:_
  - _Zip code:_
  - _Contact name:_
  - _Telephone:_

**Specify grade:**

**Is patient a school WORKER / VOLUNTEER in NC school setting?** _[ ] Y  _[ ] N  _[ ] U_
  - _Type of school:_
    - _NC Public School (preK-12)_
    - _NC Private School (preK-12)_
    - _Other School (preK-12)_
    - _Community College/College/University_
    - _Other academic institution (i.e. trade school, professional school, etc)_
  - _Name:_
  - _Address:_
  - _City:_
  - _State:_
  - _Zip code:_
  - _Contact name:_
  - _Telephone:_

**DHHS/EPI #8**

**AUGUST 2011**

**DIPHTHERIA**

**PAGE 3 OF 5**

**SSN**
### HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 10 days prior to onset until 2 days after start of antibiotics, did the patient have any of the following health care exposures?

**Emergency Dept.** (not hospitalized) ...

- [ ] Yes
- [ ] No
- [ ] Unknown

Visit/admit date (mm/dd/yyyy): __/__/____

- Facility name: __________________________
- City: ___________________ State: ___________
- Country: _____________________________

- Was facility notified regarding ill patient?
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] Not applicable

- Name of person notified: _______________________
- Date notified (mm/dd/yyyy): __/__/____

**Hospitalized** ...

- [ ] Yes
- [ ] No
- [ ] Unknown

Visit/admit date (mm/dd/yyyy): __/__/____

- Facility name: __________________________
- City: ___________________ State: ___________
- Country: _____________________________

- Has patient been discharged? ...
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] Not applicable

- Name of person notified: _______________________
- Date notified (mm/dd/yyyy): __/__/____

**LTC facility—resident** ...

- [ ] Yes
- [ ] No
- [ ] Unknown

Visit/admit date (mm/dd/yyyy): __/__/____

- Facility name: __________________________
- City: ___________________ State: ___________
- Country: _____________________________

- Has patient been discharged? ...
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] Not applicable

- Name of person notified: _______________________
- Date notified (mm/dd/yyyy): __/__/____

**Outpatient facility—patient** ...

- [ ] Yes
- [ ] No
- [ ] Unknown

Visit date (mm/dd/yyyy): __/__/____

- Facility name: __________________________
- City: ___________________ State: ___________
- Country: _____________________________

- Was facility notified regarding ill patient?
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] Not applicable

- Name of person notified: _______________________
- Date notified (mm/dd/yyyy): __/__/____

Has the patient ever worked in a healthcare or other clinical laboratory setting? ...

- [ ] Yes
- [ ] No
- [ ] Unknown

- Name of person notified: _______________________
- Date notified (mm/dd/yyyy): __/__/____

Other, specify: ____________________________________________________________

During the timeframe displayed above, has the patient had other blood and body fluid exposures? ...

- [ ] No
- [ ] Other

- Unknown

- Human saliva/oral secretions exposure (e.g., shared water bottle, cigarettes, eating utensils, kissing)? ...
  - [ ] Yes
  - [ ] No
  - [ ] Unknown

If yes, specify and give details: ________________________________________________________________

### GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specification:

- [ ] In NC
- [ ] Outside NC, but within US
- [ ] Outside US

- City: ___________________
- State: ___________________
- County: ________________

- Country: _____________________________

- Was facility notified regarding ill patient?
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - [ ] Not applicable

- Name of person notified: _______________________
- Date notified (mm/dd/yyyy): __/__/____

### BEHAVIORAL RISK & CONGREGATE LIVING

During the 10 days prior to onset until 2 days after start of antibiotics did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? ...

- [ ] Yes
- [ ] No
- [ ] Unknown

Name of facility: __________________________

Dates of contact: __________________________

During the period of interest, did the patient attend social gatherings or crowded settings? ...

- [ ] Yes
- [ ] No
- [ ] Unknown

If yes, specify: ____________________________

In what setting was the patient most likely exposed?

- [ ] Restaurant
- [ ] Home
- [ ] Work
- [ ] Child Care
- [ ] School
- [ ] University/College
- [ ] Camp
- [ ] Doctor’s office
- [ ] Outpatient clinic
- [ ] Hospital In-patient
- [ ] Hospital Emergency Department
- [ ] Laboratory
- [ ] Long-term care facility/Rest Home
- [ ] Military
- [ ] Prison/Jail/Detention Center

- Other (specify): ___________________________

- Place of Worship
- [ ] Outdoors, including woods or wilderness
- [ ] Athletics
- [ ] Farm
- [ ] Pool or spa
- [ ] Pond, lake, river or other body of water
- [ ] Hotel / motel
- [ ] Social gathering, other than listed above
- [ ] Travel conveyance (airplane, ship, etc.)
- [ ] International
- [ ] Community
- [ ] Other (specify)

- Unknown

### CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ...

- [ ] Yes
- [ ] No

Date of interview (mm/dd/yyyy): __/__/____

Were interviews conducted with others? ...

- [ ] Yes
- [ ] No

Who was interviewed? __________________________

Were health care providers consulted? ...

- [ ] Yes
- [ ] No

Who was consulted? __________________________

Medical records reviewed (including telephone review with provider/office staff)? ...

- [ ] Yes
- [ ] No

Specify reason if medical records were not reviewed: __________________________

Notes on medical record verification: __________________________
Diphtheria (*Corynebacterium diphtheriae*)

2010 Case Definition

CSTE Position Statement Number: 09-ID-05

**Case classification**

**Probable:**
In the absence of a more likely diagnosis, an upper respiratory tract illness with:
- An adherent membrane of the nose, pharynx, tonsils, or larynx; and
- Absence of laboratory confirmation; and
- Lack of epidemiologic linkage to a laboratory-confirmed case of diphtheria.

**Confirmed:**
An upper respiratory tract illness with an adherent membrane of the nose, pharynx, tonsils, or larynx; and any of the following:
- Isolation of *Corynebacterium diphtheriae* from the nose or throat; or
- Histopathologic diagnosis of diphtheria; or
- Epidemiologic linkage to a laboratory-confirmed case of diphtheria.