North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

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

DIPHTHERIA
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 8

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.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

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

Date collected	Results		Date collected	Results		Name of laboratory
	Culture	Virulence		Culture	Virulence	
/ /			/ /			
/ /			/ /			
/ /			/ /			
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 ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy): ____/____/____
Fatigue or malaise or weakness ☐Y ☐N ☐U
Cranial nerve or bulbar weakness 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
☐ Soft palate
☐ Hard palate
☐ Larynx
☐ Nares
☐ Nasopharynx
☐ Conjunctiva
☐ Skin
☐ Unknown
Soft tissue swelling around membrane ☐Y ☐N ☐U
Neck edema ☐Y ☐N ☐U
Sides
☐ Right ☐ Left ☐ Bilateral ☐ Unknown
Extent
☐ Submandibular only ☐ Below clavicle
☐ Midway to clavicle ☐ Unknown
☐ To clavicle
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:
☐ Oral ☐ Topical
☐ Intravenous (IV) ☐ Other_____
☐ Intramuscular (IM) ☐ Unknown
Specify treatment location:
☐ Outpatient ☐ Inpatient ☐ Unknown
Date antibiotic began _____
Date antibiotic ended _____
Were antibiotics given in the 24 hours before culture? ☐Y ☐N ☐U
Was diphtheria antitoxin (DAT) given? ☐Y ☐N ☐U
Specify route:
☐ Intravenous (IV)
☐ Intramuscular (IM)
☐ Unknown
Specify amount of DAT administered (IU DAT)_____
Date received: _____
Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

(CONTINUED)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE (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

County of autopsy:_____

☐ Autopsied outside NC, specify where:_____

Source of death information (select all that apply):

Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.

- ☐ Death certificate
- ☐ Autopsy report final conclusions
- ☐ Hospital/physician discharge summary
- ☐ Other:_____

Cause of death:_____

Death date (mm/dd/yyyy): ____/____/____

TRAVEL

The patient is:
- ☐ Resident North Carolina
- ☐ Resident of another state or US territory
- ☐ Foreign visitor
- ☐ Refugee

Refugee camp(s)? ☐ Y ☐ N ☐ U

Name of camp_____

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

Did patient have a travel history during the 10 days prior to onset until 2 days after start of antibiotics? ☐ Y ☐ N ☐ U

Travel dates: From:_____until _____

To city:_____State: _____

To country:_____

Reason(s) for travel:
- ☐ Vacation / tourism
- ☐ Organized tour
- ☐ Business related, specify _____
- ☐ Military related
- ☐ Visit to family / friends
- ☐ Peace corps
- ☐ Airline / Ship crew
- ☐ Missionary or dependent
- ☐ Refugee / Immigrant
- ☐ Student / Teacher
- ☐ Unknown
- ☐ Other_____

Mode(s) of transportation (check all that apply)
- ☐ Airplane
- ☐ Ship / boat / ferry
  - Cruise ship? ☐ Y ☐ N ☐ U
  - Specify cruise line _____
- ☐ Train / subway
- ☐ On foot
- ☐ Bus/taxi/shuttle
- ☐ Automobile / motorcycle
- ☐ Other, specify:_____

Did patient have contact with a person with travel history during the period of interest? ☐ Y ☐ N ☐ U

Contact's name: _____

Travel dates: From:_____until _____

To city: _____

To state:_____

To country:_____

Is contact a:
- ☐ Resident of another state or US territory
- ☐ Foreign visitor
- ☐ Recent immigrant
- ☐ Refugee
- ☐ Foreign adoptee
- ☐ Unknown
- ☐ Other, specify:_____

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:

Did patient have recent recreational drug use? ☐ Y ☐ N ☐ U

If yes, were inhalants used? ☐ Y ☐ N ☐ U

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

If yes, specify the relationship to the patient and provide contact information:

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

VACCINE

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

Vaccine #1:
Date of vaccination
(mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer:_____
Product/trade name:_____
Lot number:_____

Vaccine #2:
Date of vaccination
(mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer:_____
Product/trade name:_____
Lot number:_____

Vaccine #3:
Date of vaccination
(mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer:_____
Product/trade name:_____
Lot number:_____

Vaccine #4:
Date of vaccination
(mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer:_____
Product/trade name:_____
Lot number:_____

Vaccine #5:
Date of vaccination
(mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer:_____
Product/trade name:_____
Lot number:_____

Source of vaccine information:
- ☐ Patient's or Parent's verbal report
- ☐ Physician
- ☐ 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)*
- ☐ Patient vaccine record
- ☐ School record
- ☐ Other, specify:_____
- ☐ **NCIR record**
- ☐ Unknown

Number of doses received prior to illness: _____

Date of last diphtheria-containing vaccine prior to onset of illness:
(mm/dd/yyyy):____/____/____

Did patient receive a booster dose as an adult? ☐ Y ☐ N ☐ U

If no, reason for inadequate vaccination:
- ☐ Religious exemption
- ☐ Medical exemption
- ☐ Medical contraindication
- ☐ Philosophical exemption (outside NC only)
- ☐ Laboratory evidence of previous disease
- ☐ Physician diagnosis of previous disease
- ☐ Under age for vaccination
- ☐ Parental refusal
- ☐ Missed opportunities
- ☐ Unknown
- ☐ Other, specify:_____

Date of last booster received
(mm/dd/yyyy): ____/____/____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
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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 patient pregnant 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?
Antibiotics ☐Y ☐N ☐U
For what medical condition?_____
Chemotherapy ☐Y ☐N ☐U
If yes, was therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____
Radiotherapy ☐Y ☐N ☐U
If yes, was therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____
Systemic steroids/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: _____
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 ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify
_____
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: _____
_____

Were written isolation orders issued? ☐Y ☐N
If yes, where was the patient isolated? _____
_____
Date isolation started? _____
Date isolation ended? _____
Was the patient compliant with isolation? ☐Y ☐N
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

Patient in child care? ☐Y ☐N ☐U
Name of care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County:_____
Contact name:_____
Telephone: (_____) _____
Patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County:_____
Contact name:_____
Telephone: (_____) _____
Patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County:_____
Contact name:_____
Telephone: (_____) _____
Is patient a student? ☐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:_____County:_____
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:_____County:_____
Telephone: (_____)_____

Notes:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						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)... ☐ Y ☐ N ☐ U
- 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 ..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):____/____/____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):____/____/____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

LTC facility—resident..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):____/____/____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):____/____/____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

Outpatient facility—patient..... ☐ Y ☐ N ☐ U
- 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):____/____/____

Visitor to health care setting ..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):____/____/____
- Until date (mm/dd/yyyy):____/____/____
- Frequency:
  ☐ Once
  ☐ Multiple times within this time period
  ☐ Daily
- 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):____/____/____

Worked or volunteered in health care or clinical setting ..... ☐ Y ☐ N ☐ U
- Facility name_____
- City_____State _____
- Country _____
- Occupation:
  ☐ Physician
  ☐ Physician's assistant or nurse practitioner
  ☐ Nurse
  ☐ Laboratory
  ☐ Other
  ☐ Unknown
- Specify work setting or volunteer duties:
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

Other, specify_____

Has the patient ever worked in a healthcare or clinical laboratory setting? ..... ☐ Y ☐ N ☐ U
- If yes, specify and give details: _____

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)**?**..... ☐ Y ☐ N ☐ U
- If yes, specify and give details:

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)**?** ..... ☐ Y ☐ N ☐ U
- Name of facility:_____
- Dates of contact: _____

During the period of interest, did the patient attend social gatherings or crowded settings? ..... ☐ Y ☐ N ☐ U
- 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
☐ 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

Does the patient have any other risk factors for this disease?..... ☐ Y ☐ N ☐ U
- Specify: _____

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
- City _____
- County_____

☐ Outside NC, but within US
- City _____
- State _____
- County_____

☐ Outside US
- City _____
- Country _____

☐ Unknown

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U
- Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others?..... ☐ Y ☐ N ☐ U
- Who was interviewed?

Were health care providers consulted?..... ☐ Y ☐ N ☐ U
- Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ... ☐ Y ☐ N ☐ U

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.