California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Immunization Branch
850 Marina Bay Parkway Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Fax: (510) 620-3949

DIPHTHERIA DISEASE CASE REPORT FORM

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

Census Tract	County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information

Work / School Location	Work / School Contact

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	If Yes, Est. Delivery Date (mm/dd/yyyy)

Medical Record Number	Patient's Parent/Guardian Name

Occupation Setting	Other Describe/Specify

Occupation	Other Describe/Specify

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 7)
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

☐ American Indian or Alaska Native

☐ Asian (check all that apply, see list on page 7)
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 7)
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

BASIS FOR DIAGNOSIS

☐ Clinical only ☐ Laboratory tests

Please send sterile AND non-sterile samples from isolates of C. diphtheriae (regardless of suspected or known toxigenicity) to CDPH MDL for additional toxigenicity testing at CDC (see CDPH Quicksheet).

Type of Test	Date (mm/dd/yyyy)	Results	Name and Address of Laboratory
☐ Culture			

REMARKS (Include comment if pertinent regarding occupation economic status environment etc. Also note if other cases known in area or if this is single sporadic case.)

SIGNS AND SYMPTOMS

Upper respiratory symptoms

☐ Yes ☐ No ☐ Unknown

Fever ☐ Yes ☐ No ☐ Unknown	If Yes, highest temperature (specify F/C)
Sore throat ☐ Yes ☐ No ☐ Unknown	Neck Edema ☐ Yes ☐ No ☐ Unknown
Stridor ☐ Yes ☐ No ☐ Unknown	Tachycardia ☐ Yes ☐ No ☐ Unknown

PRESENT ILLNESS

Onset date (mm/dd/yy)	Diagnosis date (mm/dd/yy)	Hospitalized ☐ Yes ☐ No ☐ Unknown	Attending physician or consultant physician	Telephone number
Admit date (mm/dd/yy)	Discharge date (mm/dd/yy)	Medical record number	Hospital name	Telephone number
Brief clinical description (include nature and location of membrane, history of contact, probable source, etc.) (List household contacts in Remarks section.):				Did patient die? ☐ Yes ☐ No ☐ Unknown

HOSPITALIZATION

Did patient visit emergency room for illness?

☐ Yes ☐ No ☐ Unknown

Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown	How many total hospital nights?

During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)?

☐ Yes ☐ No ☐ Unknown

COMPLICATIONS

Myocarditis	Neuritis
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Other Complications	

THERAPY - SPECIFIC *(Check one)* ☐ Yes ☐ No

Antitoxin	Date (mm/dd/yyyy)	Hour	Units	Route of Administration	Manufacturer
First dose					
Second dose					
Third dose					

Therapeutic response: ☐ Prompt ☐ Delayed ☐ None

Other medical treatment (specify product)	Date of first dose (mm/dd/yyyy)	Date of second dose (mm/dd/yyyy)
Name of attending physician	Address	

ANTIBIOTIC TREATMENT

Antibiotic name	Dosage
Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Antibiotic name	Dosage
Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)

Other Medical Treatment

HISTORY OF PREVIOUS IMMUNIZATION *(Check one)* ☐ Yes ☐ No

		Date Given (mm/dd/yyyy)	Dose	Type of Product (If known) (1) fluid toxoid *OR* (2) precipitated or adsorbed toxoid
Primary Immunization	First			
	Second			
	Third			
Boosters	First			
	Second			
Diphtheria toxoid history prior to tetanus disease ☐ Yes ☐ No ☐ Unknown				
Immunocompromised ☐ Yes ☐ No ☐ Unknown				
Comments				

LABORATORY RESULTS SUMMARY

Case Lab Confirmed ☐ Yes ☐ No ☐ Unknown	
Culture Date (mm/dd/yyyy)	Culture Result
Laboratory Name	Telephone
Biotype ☐ Mitis ☐ Gravis ☐ Intermedious ☐ Belfanti	Toxigenicity testing ☐ Positive ☐ Negative ☐ Not Done ☐ Unknown
Specimen sent to CDC for confirmation / molecular typing ☐ Yes ☐ No ☐ Unknown	
Serum specimen for antitoxin antibodies obtained? ☐ Yes ☐ No ☐ Unknown	PCR testing ☐ Yes ☐ No ☐ Unknown

INCUBATION PERIOD

INCUBATION PERIOD IS 14 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

Did patient travel during the incubation period?	Did the patient have contact with travelers or visitors during the incubation period?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

PATIENT'S TRAVEL INFORMATION

Country of Residence

☐ United States	☐ Other, specify:	Date of U.S. Arrival (mm/dd/yyyy):

History of International Travel (two weeks prior to the onset)

☐ Yes ☐ No ☐ Unknown

If yes, please provide the following information:

State(s) Visited	**Month/Day/Year**	**Month/Day/Year**
1.	From:	To:
2.	From:	To:
3.	From:	To:
4.	From:	To:
5.	From:	To:

Known exposure to Diphtheria cases or carrier?	If yes, when:
☐ Yes ☐ No ☐ Unknown	
Known exposure to international travelers?	If yes, when:
☐ Yes ☐ No ☐ Unknown	
Known exposure to immigrants?	If yes, when:
☐ Yes ☐ No ☐ Unknown	

CASE DEFINITION (2019) - DIPHTHERIA (Corynebacterium diphtheriae)

CLINICAL DESCRIPTION

Upper respiratory tract illness with an adherent membrane of the nose, pharynx, tonsils, or larynx

OR

Infection of a non-respiratory anatomical site (e.g., skin, wound, conjunctiva, ear, genital mucosa)

LABORATORY CRITERIA FOR DIAGNOSIS

Confirmatory laboratory evidence:

Isolation of C. diphtheriae from any site AND Confirmation of toxin-production by Elek test or by another validated test capable of confirming toxin production

Supportive laboratory evidence:

Histopathologic diagnosis

CASE CLASSIFICATION

Suspect: In the absence of a more likely diagnosis, an upper respiratory tract illness with each of the following:

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;

OR

histopathologic diagnosis.

Confirmed: An upper respiratory tract illness with an adherent membrane of the nose, pharynx, tonsils, or larynx, **AND** any of the following:

isolation of toxin-producing C. diphtheriae from the nose or throat **OR**

epidemiologic linkage to a laboratory-confirmed case of diphtheria;

OR

an infection at a non-respiratory anatomical site (e.g., skin, wound, conjunctiva, ear, genital mucosa) with isolation of toxin-producing C. diphtheriae from that site.

COMMENT

Suspected Non-Respiratory Diphtheria: Health departments may also receive inquiries about non-respiratory (usually wound/cutaneous) cultures growing C. diphtheriae. These specimens are very unlikely to be toxigenic; however, testing should be performed to rule out toxin production (see CDPH Quicksheet).

Lab instructions: Please send sterile AND non-sterile samples from isolates of C. diphtheriae (regardless of suspected or known toxigenicity) to CDPH MDL for additional toxigenicity testing at CDC (see CDPH Quicksheet).

Investigator name (print)	Telephone number
Agency Name	
Date (mm/dd/yyyy)	

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	