State of California—Health and Human Services Agency

Caifornia Department of Public Health
Surveillance and Statistics Section
MS 7306
P.O. Box 997377
Sacramento, CA 95899-7377

DIPHTHERIA CASE REPORT

Patient name–last	first	middle initial	Date of birth	Age	Sex

Address–number, street	City	State	County	ZIP code

Telephone number
Home ( ) Work ( )

RACE (check one)
❒ African-American/Black ❒ White ❒ Native American ❒ Asian/Pacific Islander ❒ Other _____

If Asian/Pacific Islander, please check one: ❒ Asian Indian ❒ Cambodian ❒ Chinese ❒ Filipino ❒ Japanese ❒ Korean ❒ Laotian ❒ Samoan

ETHNICITY (check one)
❒ Hispanic/Latino ❒ Non-Hispanic/Non-Latino

❒ Guamanian ❒ Hawaiian ❒ Vietnamese ❒ Other _____

PRESENT ILLNESS

Onset date (mm/dd/yy)	Diagnosis date (mm/dd/yy)	Hospitalized ❒ Yes ❒ No	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.)

Outcome of case
❒ Recovered
❒ Sequelae
❒ Died—Date: _____

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

		Date Given	Dose	Type of Product (If known) (1) fluid toxoid *OR* (2) precipitated or adsorbed toxoid
Primary Immunization	First			
	Second			
	Third			
Boosters	First			
	Second			

Comments

THERAPY—SPECIFIC *(Check one)* ❒ Yes ❒ No

Antitoxin	Date	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	Date of second dose

Name of attending physician	Address

BASIS FOR DIAGNOSIS

❒ Clinical only ❒ Laboratory tests Note: Positive cultures may be sent to the State Laboratory for virulence test and typing.

Type of Test	Date	Results	Name and Address of Laboratory
❒ Smear			
❒ Culture			
❒ Virulence			

PATIENT'S TRAVEL INFORMATION

Country of Residence

❒ United States ❒ Other, specify _____ . Date of U.S. arrival _____ /_____ /_____
MM DD YY

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

❒ Yes ❒ No ❒ Unknown If yes, please provide the following information:

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

History of **Interstate** 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? ❒ Yes ❒ No ❒ Unknown If yes, when _____ where _____

Known exposure to international travelers? ❒ Yes ❒ No ❒ Unknown If yes, when _____ where _____

Known exposure to immigrants? ❒ Yes ❒ No ❒ Unknown If yes, when _____ where _____

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.)

Investigator name (print)	Date	Telephone number
		( )

Agency name

2010 CASE DEFINITION

CSTE Position Statement Number: 09-ID-05

Diphtheria (Corynebacterium diphtheriae)

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.

Comment: Cutaneous diphtheria should not be reported