U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

DIPHTHERIA SURVEILLANCE WORKSHEET

To be completed by requesting/treating clinician and returned to CDC within 14 days of DAT/S315 administration

PATIENT INFORMATION

Date of Request *(mm/dd/yyyy)* ____________ **Name** *(Last, First)* ____________ **Phone** ____________

Address *(Street and No.)* ____________ **County** ____________ **State** ______ **Zip** ______

Birth Date *(mm/dd/yyyy)* ____________

Age *Unknown=999* ______

Age Type
- 0–120 years
- 0–11 months
- 0–52 weeks
- 0–28 days
- Age unknown

Sex
- Male
- Female
- Unknown

Pregnant
- Yes
- No
- Unknown

Race
- Native Amer./Alaskan Native
- Asian/Pacific Islander
- Black/African American
- White
- Multiracial
- Other
- Unknown

Ethnicity
- Hispanic/Latino
- Not Hispanic/Not Latino
- Unknown

CLINICAL INFOMATION

Date of Symptom Onset *(mm/dd/yyyy)* ____________

Date First Diagnosis *(mm/dd/yyyy)* ____________

Date Hospitalized *(mm/dd/yyyy)* ____________

History of Immunization Against Diphtheria

Childhood primary series?	If >18 years old, number of doses	Boosters as an adult?	Date of last dose? *(mm/dd/yyyy)*
Yes / *No* / *Unknown*	______	*Yes* / *No* / *Unknown*	______ *Unknown*

Description of Clinical Picture:

SYMPTOMS

- **Fever**
- **Sore Throat**
- **Difficulty Swallowing**
- **Change in Voice**
- **Shortness of Breath**
- **Weakness**
- **Fatigue**
- **Other**

SIGNS

Fever *if Yes, Temp* ______ *°C*

Membrane? *if Yes, sites:*
Tonsils, Soft palate, Hard palate, Larynx
Nares, Nasopharynx, Conjunctiva, Skin

Soft Tissue Swelling *(around membrane)?*

Neck Edema? *if Yes, sites:*
Bilateral, Left Side Only, Right Side Only

if Yes, extent:
Submandibular, Midway to clavicle
To clavicle, Below clavicle

Stridor **Wheezing**

Palatal Weakness **Tachycardia**

EKG Abnormalities? *if Yes, describe below:*

COMPLICATIONS

Complications?

Airway Obstruction? *Onset Date (mm/dd/yyyy)* ____________

Inubation Required?

Myocarditis? *Onset Date (mm/dd/yyyy)* ____________

Poly(neuritis)? *Onset Date (mm/dd/yyyy)* ____________

Other: *Onset Date (mm/dd/yyyy)* ____________

ANTIBIOTICS

Outpatient treatment with antibiotics?
- Yes
- No
- Unknown

If Yes, date outpatient treatment initiated *(mm/dd/yyyy)* ____________

Antibiotic initiated ______ *(see codes below)*

Therapy duration ______ *(days)*

Antibiotic therapy in hospital?
- Yes
- No
- Unknown

If Yes, date inpatient treatment initiated *(mm/dd/yyyy)* ____________

Antibiotic initiated ______ *(see codes below)*

Therapy duration ______ *(days)*

Were antibiotics given in the 24 hours before specimen collection?
- Yes
- No
- Unknown

Antibiotic Codes

1 = Erythromycin (incl. Pediazole, Ilosone) or other fluoroquinolone)
2 = Penicillin (penicillin G, penicillin V K)
3 = Tetracycline, doxycycline (or other tetracycline)
4 = Amoxicillin/Augmentin/ampicillin (or other aminopenicillin)
5 = Azithromycin (or other macrolide)
6 = Trimethoprim/sulfamethoxazole
7 = Ciprofloxacin, levofloxacin
8 = Cephalexin, ceftriaxone (or other cephalosporin)
9 = Vancomycin
10 = Other (specify) ____________
11 = Unknown

CS322440-A

EXPOSURE

Country of Residence
US
Other

If Other, country name: ____________________

Date of US arrival ____________________ **or** Unknown
(mm/dd/yyyy)

History of International Travel? *(2 Weeks Prior to Onset)*
Yes
No
Unknown

Country visited: ____________________
____________ **to** ____________
(mm/dd/yyyy) *(mm/dd/yyyy)*

Country visited: ____________________
____________ **to** ____________
(mm/dd/yyyy) *(mm/dd/yyyy)*

History of Interstate Travel? *(2 Weeks Prior to Onset)*
Yes
No
Unknown

State visited: ____________________
____________ **to** ____________
(mm/dd/yyyy) *(mm/dd/yyyy)*

State visited: ____________________
____________ **to** ____________
(mm/dd/yyyy) *(mm/dd/yyyy)*

History of *(select all that apply)***?**
Homelessness
Unstable housing
IV drug use
None
Unknown

Known exposure to *(select all that apply)*
Dogs
Cats
Unpasteurized dairy
Farm animals
None
Unknown

Known exposure to diphtheria case or carrier?
Yes
No
Unknown

LABORATORY

Specimen for culture obtained?
Yes
No
Unknown

If yes, date specimen obtained? *(mm/dd/yyyy)*
____________________ **or** Unknown

Type of specimen *(check all that apply)***?**
Clinical swab
Tissue
Piece of pseudomembrane
Blood
Fluid
Other: ____________

Culture results if done?
Positive
Negative
Unknown

Performing Laboratory *(for culture)*

If positive, culture results
C. diphtheriae
C. ulcerans
C. pseudotuberculosis

Culture result confirmed by?
MALDI-TOF
Biochemical testing

PCR Result
Tox bearing
C. diphtheriae
C. ulcerans/C. pseudotuberculosis
Not done
Negative
Unknown

REPORTING

Has this suspected case been reported to the State or Local Health Department?
Yes No Unknown

Date reported to State or Local Health Department: ____________
(mm/dd/yyyy)

Health Department person Informed: ____________________

Phone ____________ **Fax** ____________ **Title** ____________

REQUESTING PHYSICIAN

Name: ____________________

Institution: ____________________

Address: ____________________ **State** ____________ **Zip** ____________

Phone ____________ **Fax** ____________ **Email** ____________

Name of Investigator Under the Investigational New Drug Protocol (IND) *(if different from requesting physician)***:** ____________

Phone ____________ **Fax** ____________

Product Requested:
Equine DAT
Monoclonal antibody S315

SEND DAT TO

Name: ____________________

Institution: ____________________

Address: ____________________ **State** ____________ **Zip** ____________

Phone ____________ **Fax** ____________ **Email** ____________

DOSE

Amount of DAT/S315 Administered: ____________ **Date administered:** ____________

Adverse Event Reported?
Yes No Unknown

DISPOSITION

Final Diagnosis:

Final Diagnosis Confirmed By?

Final Case Disposition
Confirmed
Suspect
Not a Case/Carrier
Carrier

Outcome
Recovered
Deceased
Unknown