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

Appendix 3: CDC Diphtheria Worksheet

PATIENT INFORMATION

Date of Request ☐☐ ☐☐ ☐☐ Month Day Year

Name (Last, First)

Birth Date ☐☐ ☐☐ ☐☐ Month Day Year

Age ☐☐☐ Unk = 999

Age Type ☐
0 = 0-120 years
1 = 0-11 months
2 = 0-52 weeks
3 = 0-28 days
9 = Age unknown

Sex ☐
M = Male
F = Female
U = Unknown

Pregnant? ☐
Y = Yes
N = No
U = Unknown

Race ☐
N = Native Amer./Alaskan Native
A = Asian/Pacific Islander
B = African American
W = White
O = Other
U = Unknown

Ethnicity ☐
H = Hispanic
N = Not Hispanic
U = Unknown

Address (Street and No.) | **County** | **State** | **Zip** | **Phone**

Date Symptom Onset ☐☐ ☐☐ ☐☐ Month Day Year

Date First Diagnosis ☐☐ ☐☐ ☐☐ Month Day Year

Date Hospitalized ☐☐ ☐☐ ☐☐ Month Day Year

History of Immunization Against Diphtheria

Childhood Primary Series? ☐
Y = Yes
N = No
U = Unknown

If < 18 Years Old, Number of Doses ☐

Boosters as Adult? ☐
Y = Yes
N = No
U = Unknown

Date of Last Dose ☐☐ ☐☐ ☐☐ Month Day Year **OR** ☐ U = Unk

Description of Clinical Picture

Outcome ☐
N = Recovered, No Residua
R = Recovered, Residua
D = Died
U = Unknown

CLINICAL INFORMATION

Enter Y = Yes, N = No, or U = Unknown in the Boxes Below Unless Otherwise Indicated

Symptoms

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

Signs

- Fever? ☐
- If Yes, Temp ☐☐☐.☐ °C
- Membrane? ☐
- If Yes, Site(s)
  - Tonsils ☐
  - Soft Palate ☐
  - Hard Palate ☐
  - Larynx ☐
  - Nares ☐
  - Nasopharynx ☐
  - Conjunctiva ☐
  - Skin ☐
- Soft Tissue Swelling? (Around Membrane) ☐
- Neck Edema? ☐
- If Yes ☐ B = Bilateral, L = Left Side Only, R = Right Side Only
- If Yes, Extent ☐ S = Submandibular Only, M = Midway to Clavicle, C = To Clavicle, B = Below Clavicle
- Stridor? ☐
- Wheezing? ☐
- Palatal Weakness? ☐
- Tachycardia? ☐
- EKG Abnormalities? ☐

Complications

- Complications? ☐
- Airway Obstruction? ☐
- Date of Onset ☐☐ ☐☐ ☐☐ Month Day Year
- Intubation Required? ☐
- Myocarditis? ☐
- Date of Onset ☐☐ ☐☐ ☐☐ Month Day Year
- (Poly)neuritis? ☐
- Date of Onset ☐☐ ☐☐ ☐☐ Month Day Year
- Other? ☐
- Describe:

LABORATORY

Specimen for Diphtheria Culture Obtained? ☐
Y = Yes
N = No
U = Unknown

If Yes, Obtained on ☐☐ ☐☐ ☐☐ Month Day Year **OR** ☐ U = Unknown

Culture Result ☐
P = Positive
N = Negative
U = Unknown

Specify Lab Performing Culture:

If Culture Positive, Biotype ☐
M = Mitis
G = Gravis
I = Intermedious
B = Belfanti

If Culture Positive, Results of Toxigenicity Testing ☐
X = Not Done
P = Positive
N = Negative
U = Unknown

Specimen Sent to CDC Diphtheria Lab for Confirmation/Molecular Typing? ☐
Y = Yes
N = No
W = Will be Sent

Type of Specimen (Check All That Apply)
☐ Clinical Swab
☐ Piece of Membrane
☐ *C. diphtheria* Isolate

Serum Specimen for Diphtheria Antitoxin Antibodies Obtained? ☐
Y = Yes
N = No
W = Will be Obtained Prior to DAT

PCR Result ☐
P = Positive
N = Negative
U = Unknown
X = Not Done

ANTIBIOTICS

Treated with Antibiotics? ☐
Y = Yes
N = No

As an Outpatient
If Yes, Date Initiated ☐☐ ☐☐ ☐☐ Month Day Year
Antibiotic ☐ See Codes Below
Duration of Therapy ☐☐ Days

Antibiotic Therapy in Hospital? ☐
Y = Yes
N = No

As an Inpatient
If Yes, Date Initiated ☐☐ ☐☐ ☐☐ Month Day Year
Antibiotic ☐ See Codes Below
Duration of Therapy ☐☐ Days

Were Antibiotics Given in the 24 Hours Before Culture? ☐
Y = Yes
N = No
U = Unknown

1 = Erythromycin (Incl. Pediazole, Ilosone)
2= Penicillin (Bicillin, Pfizerpen-AS, Wycillin)
3 = Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixime
4 = Clarithromycin/azithromycin
5 = Cotrimoxazole (Bactrim/Septra)
6 = Tetracycline/Doxycycline
7 = Other
9 = Unknown

Note: This Form Has 2 Sides

EXPOSURE

Country of Residence
U = US
O = Other

If Other, Country Name:

Date of US Arrival
Month Day Year OR U = Unknown

History of International Travel?
(2 Weeks Prior to Onset)
Y = Yes
N = No
U = Unknown

Country(s) Visited

	From			To		
	Month	Day	Year	Month	Day	Year

History of Interstate Travel?
(2 Weeks Prior to Onset)
Y = Yes
N = No
U = Unknown

State(s) Visited

	From			To		
	Month	Day	Year	Month	Day	Year

Known Exposure to Diphtheria Case or Carrier?
Y = Yes
N = No
U = Unknown

Known Exposure to International Travelers?
Y = Yes
N = No
U = Unknown

Known Exposure to Immigrants?
Y = Yes
N = No
U = Unknown

REPORTING INFORMATION

Has This Suspected Case Been Reported to The State or Local Health Department?
Y = Yes
N = No
U = Unknown

Date Reported to State or Local Health Department
Month Day Year

Person Informed: Phone - - Fax - -

Reporting Physician: Phone - - Fax - -

REQUESTING PHYSICIAN

Name

Institution

Street

City State Zip

Phone - - Fax - -

Name of Investigator Under the IND (If Different From Requesting Physician) Phone - - Fax - -

SEND DRUG TO

Name

Attn.

Institution

Street

City State Zip

Phone - - Fax - -

DOSE

Amount of DAT Administered: , IU DAT

DISPOSITION

Final Diagnosis:

How Was the Final Diagnosis Confirmed?

Final Case Disposition
C = Confirmed
P = Probable
N = Not a Case

This document can be found on the CDC website at:
https://www.cdc.gov/diphtheria/downloads/appendix-3-diphtheria-worksheet.pdf