Diphtheria

ORPHEUS ID

☐ confirmed
☐ presumptive
☐ suspect
☐ no case

☐ respiratory
☐ carrier
☐ cutaneous
☐ case

Name _____ County_____
LAST, first, initials (a.k.a.)

Address _____
Street City Zip

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

E-mail _____

ALTERNATE CONTACT

Name _____ Phone(s)_____
LAST, first, initials home (H), work (W), cell (C), message (M)

Special housing
☐ Nursing home/ Asst Living
☐ Homeless
☐ Prison/jail
☐ Foster home
☐ Hospital
☐ Nursing home
☐ Other institution
☐ Drug treatment/ shelter
☐ Women's shelter
☐ YES house
☐ Homeless shelter
☐ Job Corps
☐ Treatment center
☐ Chemawa Indian School
☐ Pacific Univ.
☐ No address on file

DEMOGRAPHICS

DOB ____/____/____ if DOB unknown, AGE _____ Sex ☐ Female ☐ Male Preg ☐ Y ☐ N ☐ UNK
m d y

Language _____ Country of birth _____ ☐ refugee

Worksites/school/day care center _____ Occupation/grade_____

Amer Indian/ Alaska Native
☐ American Indian
☐ Alaska Native
☐ Canadian Inuit, Metis First Nation
☐ Indigenous Mexican Central American South American

HISPANIC or Latino/a
☐ Hispanic or Latino/a Central American
☐ Hispanic or Latino/a Mexican
☐ Hispanic or Latino/a South American
☐ Other Hispanic or Latino/a

ASIAN
☐ Asian Indian
☐ Chinese
☐ Filipino/a
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ South Asian
☐ Vietnamese
☐ Other Asian

Native Hawaiian/ Pacific Islander
☐ Guamanian or Chamorro
☐ Micronesian
☐ Native Hawaiian
☐ Samoan
☐ Tongan
☐ Other Pacific Islander

Black or African American
☐ African American
☐ African (Black)
☐ Caribbean (Black)
☐ Other Black

Middle Eastern Northern African
☐ Northern African
☐ Middle Eastern

White
☐ Eastern European
☐ Slavic
☐ Western European
☐ Other White

Other Categories
☐ Other (please list)
_____
☐ Don't know/Unknown
☐ Don't want to answer/ Decline

_____

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
_____
_____
_____

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
_____
_____
_____

☐ Ok to contact patient (only list once)
Local epi_name_____
Date report received by LHD ____/____/____LHD completion date ____/____/____

CASE'S NAME

BASIS OF DIAGNOSIS - DIPHTHERIA

CLINICAL DATA

Onset date (first s/s) ____/____/___

Diagnosis date ____/____/_____

Check all that apply

y n r u

☐ ☐ ☐ ☐ sore throat
☐ ☐ ☐ ☐ stridor
☐ ☐ ☐ ☐ lymphadenophathy
☐ cervical ☐ postarticular ☐ suboccipital
☐ supraclavicular ☐ auxillary ☐ submental
☐ other
☐ ☐ ☐ ☐ hoarseness
☐ ☐ ☐ ☐ pharyngitis
☐ ☐ ☐ ☐ pharyngeal membrane

HOSPITALIZATION

Deceased: ☐ yes ☐ no
if yes, date of death ____/____/____

Cause: _____
☐ related to disease ☐ unrelated to disease ☐ unk

Hospitalized: ☐ yes ☐ no ☐ unk
Hospital Name _____
admit date ____/____/____ ☐ ICU
discharge date ____/____/____

Hospital Name _____
admit date ____/____/____ ☐ ICU
discharge date ____/____/____

LABORATORY DATA

Laboratory Name _____
Collection date ____/____/____
Result date ____/____/____

Virus isolation

pos neg unk not done
☐ ☐ ☐ ☐ throat swab ____/____/____
☐ ☐ ☐ ☐ Urine ____/____/____

PCR

☐ ☐ ☐ ☐ throat swab ____/____/____
☐ ☐ ☐ ☐ urine ____/____/____

Serology

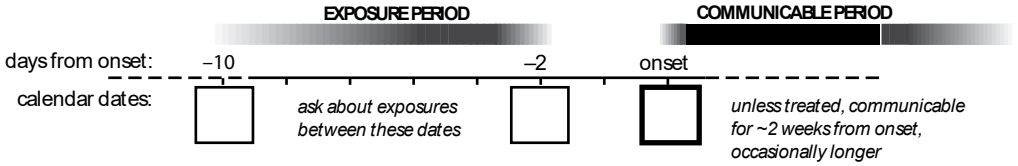
pos neg unk not done
☐ ☐ ☐ ☐ date IgM specimen taken ____/____/____
☐ ☐ ☐ ☐ date IgG Acute specimen taken ____/____/____
☐ ☐ ☐ ☐ date IgG Convalescent specimen taken ____/____/____

Isolate sent to public health lab

CASE'S NAME

INFECTION TIMELINE

Enter onset date of rash in heavy box. Count forwards and backwards to figure probable exposure and communicable periods.



Interviewed ☐ yes ☐ no Interview date(s) _____ Interviewed by _____

Who ☐ patient ☐provider ☐ parent ☐ other

Reason not interviewed (choose one)

☐ not indicated ☐ unable to reach ☐ out of jursdiction ☐ deceased
☐ refused ☐ physician interview ☐ medical record review

POSSIBLE SOURCES OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case was already epi-linked.

RISKS

y n u r

☐ ☐ ☐ ☐ Travel outside the home area
When _____
*Where*_____
☐ ☐ ☐ ☐ contact of suspect case
☐ ☐ ☐ ☐ prior vaccination
☐ ☐ ☐ ☐ places where exposed (check boxes to right)
☐ ☐ ☐ ☐ other risk, specify in notes

Places where exposed

☐ daycare ☐ work ☐ other
☐ school ☐ college ☐ unknown
☐ doctor's office ☐ military
☐ hospital ward ☐ correctional facility
☐ hospital ER ☐ place of worship
☐ hosp.outpatient clinic ☐ international travel
☐ home

FOLLOW-UP

y n u r

☐ ☐ ☐ ☐ contact with infants
☐ ☐ ☐ ☐ contact with pregnant women
☐ ☐ ☐ ☐ contact with immunocompromised patients

Settings where the case may have exposed others during infectious period

☐ daycare ☐ hospital ward ☐ >1 setting outside household ☐ college ☐ place of worship
☐ school ☐ hospital ER ☐ work ☐ military ☐ international travel
☐ doctor's office ☐ hosp.outpatient clinic ☐ unknown ☐ correctional facility ☐ other
☐ no documented spread

EPI-LINKAGE

y n u During the exposure period, was the patient

☐ ☐ ☐ associated with known outbreak
☐ ☐ ☐ close contact of *confirmed* or *presumptive* case

Nature ☐ coworker ☐ daycare ☐ friend ☐ household ☐ sexual ☐ _____

☐ ☐ ☐ has case been reported

Epi-link ☐ household ☐ sporadic ☐ outbreak

Exposure type
☐ single ☐ multiple ☐ unknown

Exposure date and time ___/___/___ _____

Outbreak ID_____

Is the patient aware of anyone with a similar illness? Provide contact information and other relevant details.

CASE'S NAME _____

IMMUNIZATION HISTORY

Up to date for diphtheria ☐ yes ☐ no ☐ unk

Vaccine	*Date*	*Source choose one:* ALERT / Provider / Verbal (Shot card) / Verbal (not verified)
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

If you have access to ALERT, please print the vaccination history and staple to this form.

Vaccinated: ☐ yes ☐ no ☐ unk
if not vaccinated, why not?
☐ Religious exemption
☐ Medical contraindication
☐ Philosophical exemption
☐ Previous culture/MD confirmed
☐ Parental/patient refusal
☐ age <2 months

☐ Forgot
☐ Inconvenience
☐ Too expensive

☐ Concurrent illness
☐ Parent/patient unaware
☐ Vaccination records incomplete (unavailable)
☐ Other

CONTACT MANAGEMENT

Add additional sheets as necessary	Contact 1	Contact 2
Name (First, middle, last, no initials please)		
Phone number		
Address (street, city)		
Address, (county, zip)		
Date of birth/ age mm/dd/yyyy or years of age	___/___/___	___/___/___
High risk	☐ Yes ☐No	☐ Yes ☐No
Sex	☐ Male ☐Female	☐ Male ☐Female
Pregnant	☐ Yes ☐No *if yes*, due date ___/___/___	☐ Yes ☐No *if yes*, due date ___/___/__
Relation to case (coworker, daycare, friend, household, infant, unborn baby)		
Occupation		
Sick	☐ Yes ☐No *if yes*, onset date ___/___/__	☐ Yes ☐No *if yes*, onset date ___/___/__
First exposure / Last exposure	First exposure ___/___/___ Last exposure ___/___/___	First exposure ___/___/___ Last exposure ___/___/___
Location of exposure		
Education provided?	☐ Yes ☐No *if yes*, date ___/___/___	☐ Yes ☐No *if yes*, date ___/___/___
MMR 1 mm/dd/yyyy	___/___/___	___/___/___
MMR 2 mm/dd/yyyy	___/___/___	___/___/___
History of prior disease (circle one)	☐ Yes ☐No ☐ Unk	☐ Yes ☐No ☐ Unk
Up-to-date for disease (circle one)	☐ Yes ☐No ☐ Unk	☐ Yes ☐No ☐ Unk
Vax count		
Specimen (date), test type, result		
Lab name		

ADMINISTRATION

JULY 2019

Case report sent to OHA on ___/___/___ ` **Investigation sent to OHA on** ___/___/___

Completed by _____ **Date** _____ **Phone** _____