### DIPHTHERIA INVESTIGATION FORM

**This form should be completed in full for each suspected Diphtheria case/contact**

#### INVESTIGATOR DETAILS
- **Name**
- **Surname**
- **Contact number**
- **Date of investigation**

#### SOURCE(S) OF INFORMATION
- **Interview**
  - [ ] Yes
  - [ ] No
- **Medical record review**
  - [ ] Yes
  - [ ] No

#### Person(s) interviewed
- Clinician
- Parent
- Caregiver
- Guardian
- Patient
- Contact

#### DEMOGRAPHIC DETAILS
- **Name**
- **Surname**
- **Date of birth**
- **Age (years)**
- **Gender (M/F)**
- **Contact number**

#### Race
- [ ] Black
- [ ] Coloured
- [ ] Indian
- [ ] White
- [ ] Other
- **Specify other**

#### Residential address
- **Code**
- **District**
- **Province**

#### Occupation
- **Is the person a learner?**
  - [ ] Yes
  - [ ] No

#### If learner, name of school
- **Grade**

#### CLINICAL DETAILS
- **Symptomatic? (Y/N)**
- **If symptomatic date of onset of symptoms**

#### If symptomatic, tick all the listed symptoms below that the person experienced:
- [ ] Fever
- [ ] Swollen neck
- [ ] Fatigue
- [ ] Shortness of breath
- [ ] Difficulty swallowing
- [ ] Malaise
- [ ] Sore throat
- [ ] Stridor
- [ ] Change in voice
- [ ] Membrane in mouth
- [ ] Other
- **If other, specify**

#### Did the person experience any complications? (Y/N)

#### If complications experienced, tick all the listed complications below that the person experienced:
- [ ] Airway obstruction
- [ ] Myocarditis
- [ ] Peripheral neuritis
- [ ] Kidney failure
- [ ] Other
- **If other, specify**

#### List any comorbidities

#### ADMISSION DETAILS
- **Admitted? (Y/N)**
- **Previous admissions in the last year? (Y/N)**
- **Number of previous admissions**

#### Date of current admission
- **Health facility name**

#### Ward
- **Placed in isolation? (Y/N)**
- **Outcome**
  - [ ] Died
  - [ ] Discharged
  - [ ] UNK/RHT

#### Admission/facility record number
- **Outcome date**

#### Was patient referred? (Y/N)
- **Name of referring facility**

#### Date of referral
- **Date of first presentation**

#### TREATMENT INFORMATION
- **Is person on antibiotic therapy? (Y/N)**
- **Name of antibiotic**

#### Dose (mg)
- **Date start**
- **Date finish**

#### Has this person received Diphtheria Anti-Toxin? (Y/N)

#### VACCINATION HISTORY
- **Vaccination history available? (Y/N)**
- **Source of history**
  - RTHC
  - Medical records
  - Self-reported

#### Primary series of vaccinations
- **Booster doses**
  - [ ] 6 weeks
    - **Date received**
    - **Date received**
  - [ ] 10 weeks
    - **Date received**
    - **Date received**
  - [ ] 14 weeks
    - **Date received**

#### EXPOSURE HISTORY

#### Travel history
- **Has this person travelled outside the borders of South Africa within 10 days prior to onset of illness? (Y/N)**

#### If yes, specify country (ies) visited

#### Date of departure from South Africa
- **Date of return to South Africa**

#### Has this person travelled within the borders of South Africa within 10 days prior to onset of illness? (Y/N)

#### If yes, specify area(s) visited below:
<table>
<thead>
<tr>
<th>Place visited</th>
<th>Date of arrival</th>
<th>Date of departure</th>
</tr>
</thead>
<tbody>
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</table>

**Contact history**

Has this person had contact with a suspected or confirmed diphtheria case? (Y/N)

If yes, provide details of the suspected or confirmed case:

*Include name, address, contact details*

Has this person had contact with any person(s) with similar symptoms or illness? (Y/N)

If yes, provide details of the symptomatic or ill person(s):

*Include name, address, contact details*

Has this person attended any gatherings within 10 days prior to onset of illness? (Y/N)

If yes, provide details:

<table>
<thead>
<tr>
<th>Name of event</th>
<th>Location</th>
<th>Date of event</th>
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</table>

**LABORATORY INFORMATION**

Were specimens collected from this person for laboratory testing? (Y/N)  
Collection date

<table>
<thead>
<tr>
<th>Specimen type</th>
<th>Nasal swab</th>
<th>Throat swab</th>
<th>Skin/wound swab</th>
<th>Other</th>
<th>Specify other</th>
</tr>
</thead>
</table>

Health facility laboratory specimen number

**Test conducted**  
**Test result**

**DATA CAPTURE INFORMATION**

Data capture date  
Data capturer name  
Line-list record number