NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

DIPHTHERIA CONTACT LINE LIST

health
Department: Health
REPUBLIC OF SOUTH AFRICA

Confirmed Case Information

Surname	Name	Age	DOB	City/Town/ Village	District	Province	Date of Symptom Onset	Date of Admission to hospital	Date of Death
							dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy

For all information pertaining to location, please list information on where the contact will be residing for the next week.

Contact Information

Surname	Name	Sex (M/F)	Age (yrs)	DOB	Relation to Case	Date of Last Contact with Case	Type of Contact (1 or 2)* List all	Street address	City/Town	District	Contact Phone Number	Learner or Employed (Y/N) *If yes,* school or workplace name?	Swab Taken (Y/N) Date	Antibiotic Prophylaxis Given (Y/N) Date	Vaccine Given (Y/N) Date
						dd/mm/yyyy									
						dd/mm/yyyy									
						dd/mm/yyyy									
						dd/mm/yyyy									
						dd/mm/yyyy									

***Types of Contact:**
1 = Had direct physical contact with the body of the case (alive or dead)
2 = Slept or spent time in the same household or room as the case

Completed by: **Surname and name:**_____ **Cell number :**_____ **Date:**_____