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

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		**6 years** ☐	Date received	
10 weeks ☐	Date received		**12 years** ☐	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:			

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Place visited	Date of arrival	Date of departure

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:	

Name of event		**Location**		**Date of event**	

LABORATORY INFORMATION

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

Specimen type	Nasal swab☐	Throat swab☐	Skin/wound swab☐	Other☐	Specify other

Health facility laboratory specimen number	
Test conducted	***Test result***

DATA CAPTURE INFORMATION

Data capture date		**Data capturer name**		**Line-list record number**	