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**	