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**			
Residential address							
Postal Code		**District**		**Province**			
Type of residence (select all that apply)	Urban☐	Peri-urban☐	Rural☐	Formal☐	Informal☐		
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☐			
Endocarditis ☐							
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)							

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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:			
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**
Substance use/abuse			
Has this person used any illicit substance within 10 days prior to onset of illness? (Y/N)			
If yes to previous question, complete attached substance use/abuse questionnaire			

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**	

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Substance use/abuse questionnaire

DRUG CATEGORY (Includes nonmedical drug use) **Note:** Use card sort with drug category names to first determine which drugs have ever been used then ask for information for the drugs ever used	Ever Used Circle Yes or No[a]	Total Years Used[b]	Intravenous Drug Use NA=Not Applicable	Year Last Used (e. g., 2021)	Frequency of Use Past 6 Months[c]
ALCOHOL	No Yes				
CANNABIS: Marijuana, hash oil, pot, weed, blow	No Yes				
STIMULANTS: Cocaine, crack, blow	No Yes				
STIMULANTS: Methamphetamine — meth, ice, crank	No Yes				
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine, speed, bennies, uppers	No Yes				
BENZODIAZEPINES/ TRANQUILIZERS: Valium, Librium, Xanax, Diazepam, roofies, downers	No Yes				
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital	No Yes				
HEROIN: smack, scat, brown sugar, dope	No Yes				
STREET OR ILLICIT METHADONE	No Yes				
OTHER OPIOIDS: Tylenol #2 & #3, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid	No Yes				
HALLUCINOGENS: LSD, PCP, mescaline, peyote, mushrooms, ketamine, ecstasy (MDMA)	No Yes				
INHALANTS: glue, gasoline, aerosols, paint thinner, poppers, rush, whippets	No Yes				
STEROIDS: Deca-Durabolin, Durabolin, Equipoise, Winstrol, Anadrol, Oxandrin, roids, juice	No Yes				
ILLEGAL USE OF PRESCRIPTION DRUGS (describe) _____	No Yes				

[a] **If EVER USED is NO** for any given line, the **remainder of the line should be left blank**.

[b] **Infrequent Use** (≤ 2 x/year) **or Brief Experimental Use** (< 3 months lifetime use) = **write 87**

[c] **Frequency Codes**:
0 = no use
1 = < 1x/mo.
2 = 1x/mo.
3 = 2 to 3x/mo.
4 = 1x/wk.
5 = 2 to 3x/wk.
6 = 4 to 6x/wk.
7 = daily;