Diphtheria Case Investigation Form

1st copy to be sent to laboratory with specimen, 2nd copy to DHO/ AS office and 3rd copy to be kept in the reporting health facility

PART I: For Use by Reporting Facility and DHO/ Agency Surgeon

Name of Reporting Health Facility: _____
Union Council: _____Tehsil/City: _____
District: _____Province/Area: _____
Date Patient Visited Hospital: _____/_____/_____
PAK/Province Code/District ID/Year/Diph/Case Serial # # # #
Patient's Name: _____Sex: Male/ Female
Father's Name: _____
Date of Birth: _____/_____/_____ Age: _____Months
Address of Patient: Village/Street/Mahalla_____
Union Council: _____ Tehsil/Taluka/City_____
District: _____Province/Area: _____
Clinical evidence: ☐ Sore Throat ☐ Low Grade Fever ☐ Adherent Membrane
Date of onset: _____/_____/_____
Number of Pentavalent vaccine doses received (circle): Nil/ One/ Two/Three
Date of last dose of pentavalent vaccination: _____/_____/_____
Type of specimen (circle): Nasal swab Throat swab
Date of Specimen Collection: ____ / _____/ _____ _____/_____/_____
Date of Specimen S e n t to Lab: ____ / _____/_____ ____ / _____/_____
Lab Result to be Sent to: (EDO-H, DSC/SO-WHO, Provincial and Federal officials) and
Name: _____ Telephone/FAX: _____ Email: _____
Address: _____
Name of person completing the form: _____
Designation: _____ Signature: _____D a t e : _____/_____/_____

PART II: For Use by Receiving Laboratory

Type of specimen (circle): Nasal swab Throat swab
Date specimens received at lab: _____ /____ / ____ _____/_____/_____
Lab Number: _____ _____
Condition of specimen:
Quantity Adequate: Yes No Yes No
Cold Chain OK Yes No Yes No
Specimen Received by:
Name: _____ _____
Designation: _____ _____
Date of Lab Test done: _____ / ____ / _____ _____/_____/_____
Type of test done: _____ _____
Test result: _____ _____
Comment: _____
Report sent by: Nam: _____ Signature: _____
Designation: _____ Date: _____