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| **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 |

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| **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 : \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |