**Toxigenic *Corynebacterium diphtheriae* / *ulcerans* infections:**

**GP follow-up for patient outcome**

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| Please complete and return to: | Immunisation and Vaccine Preventable Diseases Division  UK Health Security Agency  61 Colindale Avenue, London, NW9 5EQ  Telephone: 020 8327 7828  Email: [diphtheria\_tetanus@ukhsa.gov.uk](mailto:diphtheria_tetanus@ukhsa.gov.uk) or [phe.diphtheria.tetanus@nhs.net](mailto:phe.diphtheria.tetanus@nhs.net) | |
| **Personal details** | | |
| Patient name:­­­­ Enter patient name  Date of birth: Patient date of birth  NHS number: Patient NHS number | | Sex: Male  Female  Ethnicity: Enter patient ethnicity (if known) |

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| **Patient outcome** | | | | | | | | |
| Recovering well or recovered | | | Died:  Date of death: Enter date of death | | | | | |
| Ongoing care required | | | Not known (NK) | | | | | |
| If yes, please give details of ongoing care: Enter details of ongoing care | | | | | | | | |
| Was the patient admitted to hospital? | | | | | | Yes ☐ No ☐ NK ☐ | | |
| If yes, date of admission: Date of admission | | | | | | Date of discharge: ­­Date of discharge | | |
| Was the patient admitted to ICU and/or on ventilation? | | | | | | Yes  No  NK | | |
| Date of ICU admission (if applicable): | | | | Date of ICU admission | | | | |
| Duration of ICU admission (days): | | | | Duration of ICU admission | | | | |
| Has the patient experienced any complications due to diphtheria? | | | | | | | | Yes  No  NK |
| If yes, please include details of time of onset, duration and treatment required | | | | | | | | |
|  | Complication | Onset date | | | Duration (days) | | Treatment required | |
|  | Myocarditis | Date myocarditis | | | Duration myocarditis | | Treatment myocarditis | |
|  | Neuritis | Date neuritis | | | Duration neuritis | | Treatment neuritis | |
|  | Breathing problems | Date breathing problems | | | Duration breathing problems | | Treatment breathing problems | |
|  | Other | Date other | | | Duration other | | Treatment other | |

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| Please specify other complication: Click or tap here to enter text. |
| Please provide any further details regarding complications of diphtheria: Enter any additional information of complications |

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| **Vaccination history** | | | | | |
| Has the patient ever received a diphtheria-containing vaccine? | | | | Yes  No  NK | |
| Please provide details of vaccine history: | | |  | | |
| Dose | Received | Date | | | Vaccine |
| Dose 1 (primary) | Yes  No  NK | Date dose 1 | | | Vaccine 1 |
| Dose 2 (primary) | Yes  No  NK | Date dose 2 | | | Vaccine 2 |
| Dose 3 (primary) | Yes  No  NK | Date dose 3 | | | Vaccine 3 |
| Dose 4 (booster) | Yes  No  NK | Date dose 4 | | | Vaccine 4 |
| Dose 5 (booster) | Yes  No  NK | Date dose 5 | | | Vaccine 5 |
| Additional booster | Yes  No  NK | Date add. booster 1 | | | Add. booster 1 |
| Additional booster | Yes  No  NK | Date add. booster 2 | | | Add. booster 2 |
| Any additional information about vaccination history: Click or tap here to enter text. | | | | | |

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| **Patient management** | | | | |
| Has the patient received any diphtheria toxoid-containing vaccines since their diagnosis (as recommended by the [National Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1083946/Diphtheria-guidelines-2022-v16.1.pdf))? | | | Yes  No  NK | |
| Note: no booster dose is required if the last dose was given within the last 12 months prior to diphtheria infection | | | | |
| Did the patient receive antibiotics? | | Yes  No  NK | | |
| If yes, please list any or all antibiotics below: | | | | |
| Antibiotic | Date commenced | | | Duration (days) |
| Antibiotic 1 | Date antibiotic 1 | | | Duration antibiotic 1 |
| Antibiotic 2 | Date antibiotic 2 | | | Duration antibiotic 2 |
| Antibiotic 3 | Date antibiotic 3 | | | Duration antibiotic 3 |
| Antibiotic 4 | Date antibiotic 4 | | | Duration antibiotic 4 |
| Antibiotic 5 | Date antibiotic 5 | | | Duration antibiotic 5 |
| Any additional information about antibiotic treatment (that is, any reason for change): Enter any additional information about antibiotic treatment | | | | |
| Any other comments regarding patient outcome or recovery: Enter any additional information on patient outcome or recovery | | | | |

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| **Reporter details** |
| Reporter name: Reporter name  Reporter position: Reporter position  Date form filled out: Click to enter a date |