

# Pertussis

## PATIENT DEMOGRAPHICS

Name (last, first): _____	*Birth date: __/__/____ Age: _____
Address: _____	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
City/State/Zip: _____	*Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
Phone (home): _____ Phone (work) : _____	*Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. (Mark all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk
Occupation/grade: _____ Employer/School: _____	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____	

## INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigator : _____	WVEDSS ID: _____
Investigator phone: _____	Case Classification:
Investigation Start Date: __/__/____	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown

## REPORTING SOURCE

\*Date of report: \_\_/\_\_/\_\_\_\_ Report Source: Laboratory Hospital Physician Public Health Agency Other

Report Source Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Earliest date reported to county: \_\_/\_\_/\_\_\_\_ Earliest date reported to state: \_\_/\_\_/\_\_\_\_

Reporter Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## CLINICAL

Physician Name: \_\_\_\_\_ Physician Facility : \_\_\_\_\_

Physician Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Hospital

Was patient hospitalized for this illness?  Y  N  U

If yes: Hospital name: \_\_\_\_\_ Admit date: \_\_/\_\_/\_\_\_\_ Discharge date: \_\_/\_\_/\_\_\_\_

### Condition

Diagnosis date: \_\_/\_\_/\_\_\_\_ \* Illness onset date: \_\_/\_\_/\_\_\_\_

Was patient <12 months old?  Y  N  U If yes: Mother's age at infant birth \_\_\_\_ (in years)  U

Infant birth weight \_\_\_\_ (lbs) \_\_\_\_ (oz) or \_\_\_\_ (g)  U

### Symptoms

**Y N U**

Did the patient have a cough? If yes: cough onset date \_\_/\_\_/\_\_\_\_

Paroxysmal Cough

Whoop

Post-tussive Vomiting

Apnea

Did patient have a cough at final interview? Date of final interview: \_\_/\_\_/\_\_\_\_ Total cough duration (in days) \_\_\_\_\_

\*Complications Result of chest x-ray for pneumonia:  positive  negative  not done  unknown

**Y N U**

Did the patient have generalized or focal seizures due to pertussis?

Did the patient have acute encephalopathy due to pertussis?

Did the patient die from pertussis or complications (including a secondary infection) associated with pertussis?  
If yes Date of death: \_\_/\_\_/\_\_\_\_

### Clinical notes

## TREATMENT

**Y N U**

Were antibiotics given? If yes: Antibiotic name: \_\_\_\_\_ Antibiotic name: \_\_\_\_\_

Start date: \_\_/\_\_/\_\_\_\_ Start date: \_\_/\_\_/\_\_\_\_

Number of days actually taken: \_\_\_\_\_ Number of days actually taken: \_\_\_\_\_

**\*LABORATORY (Please submit copies of all labs to DIDE)**

Y N U

- Was laboratory testing done for pertussis?
- Were clinical specimens sent to CDC for genotyping? If yes: Date sent for genotyping: \_\_/\_\_/\_\_ Specimen type: \_\_\_\_\_
- Culture? If yes: Culture date: \_\_/\_\_/\_\_ Result:  Not done  Unknown  Positive  Negative  Indeterminate  
 Bordetella parapertussis  Other bordetella spp  Pending
- PCR? If yes: Specimen date: \_\_/\_\_/\_\_ Lab where PCR performed: \_\_\_\_\_ Result:  Positive  
 Negative  Indeterminate  Bordetella parapertussis  Other bordetella spp  Pending  Unknown  Not Done

**\*VACCINE INFORMATION**

- Did the patient receive a pertussis-containing vaccine?  Y  N  U  
 If yes: Number of doses of pertussis-containing vaccine given? \_\_\_\_  
 How many doses of pertussis-containing vaccine were given 2 weeks or more before illness onset? \_\_\_\_  
 Date of last pertussis-containing vaccine given before illness: \_\_/\_\_/\_\_

**VACCINATION RECORD**

<b>Date received:</b> __/__/__ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/__	<b>Given by:</b> Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
<b>Date received:</b> __/__/__ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/__	<b>Given by:</b> Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
<b>Date received:</b> __/__/__ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/__	<b>Given by:</b> Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
<b>Date received:</b> __/__/__ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/__	<b>Given by:</b> Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
<b>Date received:</b> __/__/__ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/__	<b>Given by:</b> Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
<b>Date received:</b> __/__/__ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/__	<b>Given by:</b> Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____

**EPIDEMIOLOGIC**

- Y N U
- \* Is this case epi-linked to a laboratory-confirmed case? If yes, case ID of epi-linked case: \_\_\_\_\_
  - \* Is this case part of a cluster or outbreak (e.g. total is 2 or more cases)? If yes, name of outbreak? \_\_\_\_\_
  - Were there one or more suspected sources of infection (a suspected source is another person with a cough who was in contact with the case 7-20 days before the case's cough)?  
Number of suspected sources of infection: \_\_\_\_ (see last page for contact tracing sheet)
  - Was there documented transmission from this case of pertussis to a new setting (outside the household)?

- Transmission Setting (where did this case acquire pertussis?):
- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Athletics                  | <input type="checkbox"/> College         | <input type="checkbox"/> Community            | <input type="checkbox"/> Correctional facility                  |
| <input type="checkbox"/> Daycare                    | <input type="checkbox"/> Doctor's office | <input type="checkbox"/> Home                 | <input type="checkbox"/> Hospital ER                            |
| <input type="checkbox"/> Hospital outpatient clinic | <input type="checkbox"/> Hospital ward   | <input type="checkbox"/> International travel | <input type="checkbox"/> Military                               |
| <input type="checkbox"/> Place of worship           | <input type="checkbox"/> School          | <input type="checkbox"/> Work                 | <input type="checkbox"/> Other <input type="checkbox"/> Unknown |

**PUBLIC HEALTH ACTIONS/NOTES**

- Earliest date of public health action: \_\_/\_\_/\_\_
- Y N U  Lost to follow up
- Post exposure prophylaxis of contacts
  - Treatment
  - Isolation
  - Education



