



PERTUSSIS CASE REPORT

PATIENT DEMOGRAPHICS

Patient name—last		first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address—number, street				City	State	ZIP code	County	
Telephone number Home () Work ()						Email:		
ETHNICITY (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		RACE (check all that apply) <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <input type="checkbox"/> Asian: <i>Please specify:</i> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Pacific Islander: <i>Please specify:</i> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____						
Country of birth				Country of residence				

COMMON LHD TRACKING DATA

CMRID Number		IZB Case ID Number		WebCMR ID Number	
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case		Reporter telephone ()	
Case investigator completing form		Investigator telephone ()		Investigator's jurisdiction	

SIGNS AND SYMPTOMS

Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough onset date ____/____/____	Paroxysmal cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Whoop <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Post-tussive vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Describe other symptoms	
Final interview date ____/____/____	Cough at final interview <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough duration at final interview (in days)		Diagnosis date ____/____/____
Does case meet clinical criteria for further investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			DOES CASE MEET CDC/CSTE CLINICAL CRITERIA? (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days hospitalized	Insurance Provider	Chest x-ray for pneumonia <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown		
Intubated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days intubated	Seizures due to pertussis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If case died, please complete and attach pertussis death worksheet
Pulmonary hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, describe:			If yes, date of death ____/____/____	

TREATMENT

1. Were antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	ABX 1 code	Date started ____/____/____	Number of days given	ANTIBIOTIC CODES: 1 = Erythromycin (includes pediazole) 2 = Trimethoprim/sulfamethoxazole (co-trimoxazole), e.g., bactrim/sepra 3 = Azithromycin 4 = Tetracycline/doxycycline 5 = Amoxicillin/Penicillin /Ampicillin/Augmentin/Ceclor 6 = Other 7 = None 8 = Clarithromycin 9 = Unknown
2. Were antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	ABX 2 code	Date started ____/____/____	Number of days given	

LABORATORY TESTS

Any lab tests done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		CASE LAB CONFIRMED (FOR LHD USE) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		CASE LAB CONFIRMED (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Culture performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Culture specimen date ____/____/____	Culture result (see codes) <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> S <input type="checkbox"/> U		LAB RESULT CODES P = Positive N = Negative I = Indeterminate E = Pending X = Not Done U = Unknown	
PCR performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PCR specimen date ____/____/____	PCR Culture result (see codes) <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> S <input type="checkbox"/> U			
WBC count performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	WBC specimen date ____/____/____	WBC results (please record percent lymphocytes)			
Other lab tests performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other lab test specimen date ____/____/____	Specify other lab tests	Other lab test results		

VACCINATION/MEDICAL HISTORY					
Received one or more doses of pertussis containing vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Number of doses prior to illness onset		
Dates of vaccination—Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Reason not vaccinated (check all that apply)					
1 <input type="checkbox"/> Personal Beliefs Exemption (PBE)		4 <input type="checkbox"/> Lab confirmation of previous disease		7 <input type="checkbox"/> Delay in starting series or between doses	
2 <input type="checkbox"/> Permanent Medical Exemption (PME)		5 <input type="checkbox"/> MD diagnosis of previous disease		8 <input type="checkbox"/> Other	
3 <input type="checkbox"/> Temporary Medical Exemption		6 <input type="checkbox"/> Under age for vaccination		9 <input type="checkbox"/> Unknown	
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
For infant cases (< 1 year old) ONLY: Name of hospital where case was born					

EPIDEMIOLOGICAL EXPOSURE HISTORY					
Setting (check all that apply)					
1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital Ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church	
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel	
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional facility	15 <input type="checkbox"/> Other	
Close contact with person(s) with cough 21 days before cough onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
	Name	Cough onset date	Relationship	Age (Years)	Same household
1		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing worksheet

Epi-linked to a lab-confirmed case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case Name or Case ID	Outbreak related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outbreak Name or Location
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CONTACT INVESTIGATION					
Setting (check all that apply)					
1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital Ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church	
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel	
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional facility	15 <input type="checkbox"/> Other	
Number of contacts for whom antibiotic was recommended			Number of ill contacts		

TIMELINE OF INFECTIOUSNESS AND STAGES OF COUGH														
WEEK	Exposure Period			Cough Onset		Infectious Period					No longer infectious			
	-3	-2	-1	0	+1	+2	+3	+4	+5	+6	+7	+8	+14	
Enter dates	___	___	___	___	___	___	___	___	___	___	___	___	___	
Stages of Cough	N.A.			Catarrhal Stage			Paroxysmal Stage					Convalescent Stage		
CASE CLASSIFICATION (FOR LHD USE)							CASE CLASSIFICATION (FOR STATE USE ONLY)							
<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown							<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown							

REMARKS

PERTUSSIS DISEASE CASE CLASSIFICATION
Clinical case definition A cough illness lasting at least 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or post-tussive vomiting, without other apparent cause (as reported by a health professional).
Laboratory criteria for diagnosis: Isolation of <i>Bordetella pertussis</i> from clinical specimen OR positive polymerase chain reaction (PCR) test for <i>B. pertussis</i> .
Case classification <i>Probable:</i> meets the clinical case definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory-confirmed case. <i>Confirmed:</i> a case that is culture positive and in which an acute cough illness of any duration is present; or a case that meets the clinical case definition and is confirmed by positive PCR; or a case that meets the clinical case definition and is epidemiologically linked directly to a case confirmed by either culture or PCR.