



Pertussis

County _____

LHJ Use ID _____
 Reported to DOH Date ____/____/____
 LHJ Classification Confirmed
 Probable
 Suspect
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No DK Date of interview ____/____/____

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: _____ days

Signs and Symptoms

Y N DK NA
 Cough Cough onset date ____/____/____
 Vomiting due to cough (post-tussive)
 Coughing in sudden bursts or fits (paroxysmal cough) Onset date ____/____/____
 Whoop
 Cough at final interview
 Cough duration (days) at last interview _____
 Date of final interview ____/____/____
 Cough lasting at least 2 weeks
 Temporarily stops breathing (apnea)
 Episodes of turning blue (cyanosis)
 Sore throat or pharyngitis
 Runny nose (coryza)
 Seizures new with disease

Predisposing Conditions

Y N DK NA
 Chronic lung disease

Clinical Findings

P = Positive
 N = Negative
 I = Indeterminate
 O = Other
 NT = Not Tested

Y N DK NA
 Pneumonia
 X-ray result: P N I O NT
 Acute encephalopathy
 Admitted to intensive care unit

Hospitalization

Y N DK NA
 Hospitalized at least overnight for this illness
 Hospital name _____
 Admit date ____/____/____ Discharge date ____/____/____
 Y N DK NA
 Died from illness Death date ____/____/____
 Autopsy Place of death _____

Vaccination

Y N DK NA
 Ever received pertussis containing vaccine
 Number of doses pertussis vaccine prior to illness: _____
 Dose 1 Type: _____ Date received: ____/____/____
 Dose 2 Type: _____ Date received: ____/____/____
 Dose 3 Type: _____ Date received: ____/____/____
 Dose 4 Type: _____ Date received: ____/____/____
 Dose 5 Type: _____ Date received: ____/____/____
 Dose 6 Type: _____ Date received: ____/____/____
 Y N DK NA
 Vaccine up to date for pertussis
 Vaccine series not up to date reason:
 Religious exemption
 Medical contraindication
 Philosophical exemption
 Previous infection confirmed by laboratory
 Previous infection confirmed by physician
 Parental refusal
 Other: _____ Unknown

Laboratory

Collection date ____/____/____
 Source _____
 P N I NT O
 B. pertussis culture (clinical specimen)
 B. pertussis PCR

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to determine probable exposure and contagious periods

Days from onset:	Exposure period		o n s e t	Contagious period*
	-21	-5		
Calendar dates:				* If treated, ≤5 days after initiation of effective antibiotic therapy

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Destinations/Dates: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the case know anyone else with similar symptoms or illness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologically linked directly to a culture or PCR confirmed case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with lab confirmed case Age of person from whom this case contracted pertussis: _____ days / months / years</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congregate living Type: <input type="checkbox"/> Barracks <input type="checkbox"/> Corrections <input type="checkbox"/> Long term care <input type="checkbox"/> Dormitory <input type="checkbox"/> Boarding school <input type="checkbox"/> Camp <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Work or volunteer in health care setting during exposure period Facility name: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visited health care setting during exposure period Facility name: _____ Number of visits: _____ Date(s): ___/___/___</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Exposure setting identified: <input type="checkbox"/> Child care <input type="checkbox"/> School <input type="checkbox"/> Doctor's office <input type="checkbox"/> Hospital ward <input type="checkbox"/> Hospital ER <input type="checkbox"/> Hospital outpatient clinic <input type="checkbox"/> Home <input type="checkbox"/> College <input type="checkbox"/> Work <input type="checkbox"/> Military <input type="checkbox"/> Correction facility <input type="checkbox"/> Church <input type="checkbox"/> International travel <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown</p>
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Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PATIENT PROPHYLAXIS/TREATMENT

Y N DK NA

Antibiotics prescribed for this illness Name: _____
Date antibiotic treatment began: ___/___/___ # days antibiotic actually taken: _____

Second antibiotic given Name: _____
Date antibiotic treatment began: ___/___/___ # days antibiotic actually taken: _____

PUBLIC HEALTH ISSUES

Y N DK NA

Work/volunteer in health care setting while contagious: Facility name: _____

Visited health care setting while contagious
Facility name: _____
Number of visits: _____ Date(s): ___/___/___

Face to face contact with newborns, unimmunized children, women > than 7 months pregnant or others at risk for severe complications

Employed in child care or preschool

Attends child care or preschool

Household member or close contact in sensitive occupation or setting (HCW, child care, food)

Documented transmission from this case
 Child care School Doctor's office
 Hospital ward Hospital ER
 Hospital outpatient clinic Home Work
 College Military Correction facility
 Church International travel
 Other: _____ Unk

PUBLIC HEALTH ACTIONS

Prophylaxis of appropriate contacts recommended
Number of contacts recommended prophylaxis: _____
Number of contacts receiving prophylaxis: _____
Number of contacts completing prophylaxis: _____

Exclude case from sensitive occupations or situations until 5 days of treatment complete or for 21 days

Exclude susceptible close contacts under 7 years until 5 days of treatment completed or for 21 days

Other Specify: _____

NOTES

Investigator _____	Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____		Record complete date ___/___/___

Pertussis: case defining variables are in **bold**. Answers are: Yes, No, Unknown to case, Not asked /Not answered