

# Pertussis

ORPHEUS ID

- confirmed
- presumptive
- suspect
- no case
- pertussis
- parapertussis
- holmesii
- bronchiseptica

Name \_\_\_\_\_

County \_\_\_\_\_

Address \_\_\_\_\_

Special housing \_\_\_\_\_

Phone number \_\_\_\_\_ / \_\_\_\_\_

home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

## ALTERNATIVE CONTACT

Name \_\_\_\_\_

Phone(s) \_\_\_\_\_

## DEMOGRAPHICS

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

if DOB unknown, AGE \_\_\_\_

Sex  Female  Male

Pregnant  Yes  No  Unk

Language \_\_\_\_\_

Country of birth \_\_\_\_\_

Worksites/school/day care center \_\_\_\_\_

Occupation/grade \_\_\_\_\_

RACE (check all that apply)

White

Black

Asian

Pacific Islander

American Indian/Alaska Native

Unknown

Other \_\_\_\_\_

HISPANIC

Yes  No

Unknown  Declined

## PROVIDERS, FACILITIES AND LABS

Reporter

Type (circle one)

\_\_\_\_\_  
name and phone number

PMD Lab-fax  
MDx Lab-phone  
ER Lab-other  
ICP HCP  
Lab-ELR

\_\_\_\_\_  
name and phone number

PMD Lab-fax  
MDx Lab-phone  
ER Lab-other  
ICP HCP  
Lab-ELR

Ok to contact patient

Local epi\_name \_\_\_\_\_

Date report received by LHD \_\_\_\_/\_\_\_\_/\_\_\_\_

LHD completion date \_\_\_\_/\_\_\_\_/\_\_\_\_

## BASIS OF DIAGNOSIS

### CLINICAL DATA

Symptomatic  yes  no  refused  unknown

Earliest cough \_\_\_\_/\_\_\_\_/\_\_\_\_

Paroxysmal \_\_\_\_/\_\_\_\_/\_\_\_\_

Diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_

Any cough  yes  no  refused  unknown

Paroxysmal/spasmodic cough  yes  no  refused  unknown

Whoop  yes  no  refused  unknown

Apnea  yes  no  refused  unknown

Cyanosis  yes  no  refused  unknown

Cold-like symptoms  yes  no  refused  unknown

Post-tussive vomiting  yes  no  refused  unknown

Cough at last interview  yes  no  refused  unknown

Duration of cough (#days) at final interview \_\_\_\_

CXR for pneumonia  positive  negative  not done  unknown  refused

Generalized or local seizures  yes  no  refused  unknown

Acute encephalopathy  yes  no  refused  unknown

Date of last interview: \_\_\_\_/\_\_\_\_/\_\_\_\_

### DEFINITIONS

- Paroxysmal/spasmodic cough: repeated violent coughs
- Whoop: high-pitched inspiratory noise
- Apnea: prolonged breathlessness; exclude cyanotic episodes after coughing paroxysms
- Cyanosis: Paleness or blueness occurring after coughing paroxysm
- Post-tussive vomiting: following coughing paroxysm
- Cold-like symptoms: you know, like a cold
- Positive chest X-ray for pneumonia: exclude other x-ray abnormality
- Acute encephalopathy: acute neurologic or mental function impairment (exclusive of seizures or postictal state)

**BASIS OF DIAGNOSIS, CONT.**

Deceased:  yes  no date of death \_\_\_/\_\_\_/\_\_\_

Cause: \_\_\_\_\_  
 related to disease  unrelated to disease  unk

Hospitalized:  yes  no  unk  
 Name \_\_\_\_\_

admit date \_\_\_/\_\_\_/\_\_\_  ICU

discharge date \_\_\_/\_\_\_/\_\_\_

admit date \_\_\_/\_\_\_/\_\_\_  ICU

discharge date \_\_\_/\_\_\_/\_\_\_

**LABORATORY DATA**  None

Laboratory Name \_\_\_\_\_

Collection date \_\_\_/\_\_\_/\_\_\_ Report date \_\_\_/\_\_\_/\_\_\_

Specimen type:  NP swab  NP aspirate

Test type:  PCR  Culture

Result:  Indeterminate  Positive  Negative  Not done  Unknown

Laboratory Name \_\_\_\_\_

Collection date \_\_\_/\_\_\_/\_\_\_ Report date \_\_\_/\_\_\_/\_\_\_

Specimen type:  NP swab  NP aspirate

Test type:  PCR  Culture

Result:  Indeterminate  Positive  Negative  Not done  Unknown

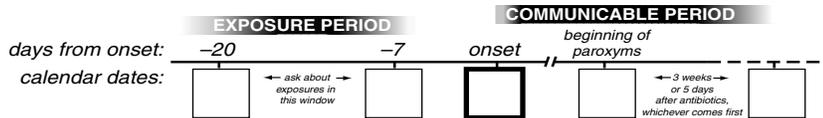
**TREATMENT**

Drug name	Size/dose/frequency	Start date	End date
_____	_____	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___
_____	_____	___/___/___	___/___/___

Comments: \_\_\_\_\_

**INFECTION TIMELINE**

Enter onset date of cough in heavy box.  
 Count forwards and backwards to figure probable exposure and communicable periods.



Interviewed  yes  no Interview date(s) \_\_\_\_\_ Interviewed by \_\_\_\_\_

Who  patient  provider  parent  other

Reason not interviewed (choose one)

- not indicated  unable to reach  out of jurisdiction  deceased
- refused  physician interview  medical record review

y n u r

- contact of possible case
- places where exposed (check boxes to right)
- Travel outside the home area
- When \_\_\_\_\_
- Where \_\_\_\_\_
- other risk

Places where exposed

- daycare  work  other
- school  college  unknown
- doctor's office  military
- hospital ward  correctional facility
- hospital ER  place of worship
- hosp.outpatient clinic  international travel
- home

**FOLLOW-UP**

y n u r

- contact with infants
- contact with pregnant women in 3rd trimester
- all household contacts of case where there is infant or pregnant woman in 3rd trimester
- daycare contacts of case if there is infant or pregnant woman in 3rd trimester
- other contacts (pediatric healthcare workers, unimmunized contacts, other pregnant women, high risk contacts of suspect cases)

Settings where the case may have exposed others during infectious period

- daycare  hospital ward  >1 setting outside household  college  place of worship
- school  hospital ER  work  military  international travel
- doctor's office  hosp.outpatient clinic  unknown  correctional facility  other
- case educated about how to reduce disease transmission  no documented spread

**EPI-LINKAGE**

- y n u
- associated with known outbreak
- close contact of another case
- Nature
- coworker     daycare
- friend         household
- infant         unborn baby
- has case been reported

- Epi-link  household  sporadic  outbreak
- Exposure type
- single  multiple  unknown
- Exposure date and time \_\_\_/\_\_\_/\_\_\_
- Outbreak ID \_\_\_\_\_
- Generation  1  2

**IMMUNIZATION HISTORY**

Up to date for pertussis  yes  no  unk    Received Tdap  yes  no  unk

Vaccine	Date	Source: Choose one ALERT / Provider / Verbal (Shot card) / Verbal (not verified)
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

- Vaccinated:  yes  no  unk  
*if not vaccinated, why not?*
- Religious exemption
- Medical contraindication
- Philosophical exemption
- Previous culture/MD confirmed
- Parental/patient refusal
- Too young
- 
- Forgot
- Inconvenience
- Too expensive
- 
- Concurrent illness
- Parent/patient unaware
- Vaccination records incomplete (unavailalbe)
- Other
- Unknown

If you have access to ALERT, please print the vaccination history and staple to this form.

**CONTACT MANAGEMENT**

If the case is an infant, and the contact is the mother, ask the following questions:

Have you ever been vaccinated with Tdap?     yes  no  mom not available for interview  unk

Were you vaccinated with Tdap during pregnancy with case infant?  yes  no  mom not available for interview

unk  infant adopted or in foster care

If yes, what trimester  1st  2nd  3rd  unk

If mother wasn't vaccinated during pregnancy with case infant, why not?

doesn't recall physician offering,  declined Tdap during pregnancy,

vaccinated following pregnancy  vaccinated prior to pregnancy  other: specify \_\_\_\_\_  unk

Be sure to enter Tdap info below:

Date	Age	Vax name	Source: Choose one ALERT Provider Verbal (Shot card) Verbal (not verified)
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____

COMMENTS

**CONTACT MANAGEMENT**

Use this page for contacts other than the mother of infant cases. Add additional pages as necessary

	Contact 1	Contact 2
Name (First, Middle [not initials] and Last)		
Phone number		
Address (street, city)		
Address, (county, zip)		
Date of birth or years of age	___/___/___	___/___/___
High risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to case*		
Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, due date</i> ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, due date</i> ___/___/___
Sick	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, onset date</i> ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, onset date</i> ___/___/___
Occupation		
Date identified	___/___/___	___/___/___
Prophy recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already on antibiotics Date recommended ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Already on antibiotics Date recommended ___/___/___
Education provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes date provided</i> ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes date provided</i> ___/___/___
Immunization** (date and vaccine type)	___/___/___	___/___/___
Date of swab (if done) and results	___/___/___ <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	___/___/___ <input type="checkbox"/> Indeterminate <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown

\*babysitter, coworker, daycare, father, friend, infant, medical, mother, mother (not biological), other household, preschool, school, sibling, unborn baby, other

\*\*If you have access to ALERT, please print the vaccination history and staple it to this form.

Comments