

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: _____

EPI-LINKAGE

During the exposure period, was the patient

- associated with a known outbreak
- a close contact of a *another* case yes no unk Related case MUST be confirmed.

Epi-link household sporadic outbreak Outbreak ID _____

Has the case been reported yes no unk

IMMUNIZATION HISTORY

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

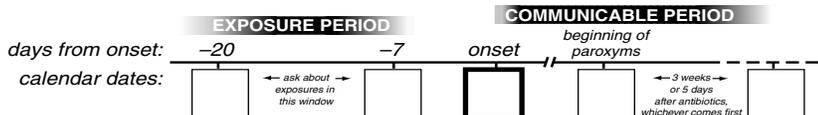
Vaccine	Date	Source: Choose one ALERT / Provider / Verbal (Shot card) / Verbal (not verified)
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

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

- Up-to-date for pertussis yes no unk
- 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 (unavailable)

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

CONTACT MANAGEMENT

Use this page for contacts other than mothers of infant cases. **If you have access to ALERT, please print the vaccination history and staple it to this form.

	Contact 1	Contact 2
Name (First, Middle [not initials] and Last)		
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*		
Sick	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, onset date ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, onset date ___/___/___
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 if yes date provided ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes date provided ___/___/___
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

Comments

	Contact 3	Contact 4
Name (First, Middle [not initials] and Last)		
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*		
Sick	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, onset date ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes, onset date ___/___/___
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 if yes date provided ___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No if yes date provided ___/___/___
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

Comments

ADMINISTRATION

MARCH 2015

Remember to copy patient's name to the top of this page.

Case report sent to OHA on ___/___/___

Completed by _____ Date _____ Phone _____ Investigation sent to OHA on _____