



Pertussis Case Track Record

NBS PATIENT ID#: _____

FINAL STATUS:

- CONFIRMED PROBABLE
 RULED OUT/DROPPED

NBS PATIENT INVESTIGATION#: _____

Patient's Name: _____
Last First

Reported By: _____

Address: _____

Agency: _____

City: _____ County: _____ Zip: _____

Phone: () - _____

Region: _____ Phone: () - _____

Date: / /

Parent/Guardian: _____

Report Given To: _____

Physician: _____ Phone: () - _____

Organization: _____

Physician's Address: _____

Phone: () - _____

Date: / /

DEMOGRAPHICS:

DATE OF BIRTH: / / AGE: Infant (<1 year old) SEX: Male Female Unknown
RACE: White Black Asian Native Hawaiian or Other Pac. Islander Am. Indian or Alaska Native Unknown Other: _____
HISPANIC: Yes No Unknown

CLINICAL DATA:

Final Cough

Cough - Onset Date: / / Duration (total # of days):

***At least one must be chosen to meet Confirmed or Probable case definition.**

Paroxysmal Cough Onset Date: / /

Inspiratory Whoop

Vomiting after Paroxysm

Apnea (with or without cyanosis) *For <1 year old ONLY*

***Additional Symptoms**

Acute Encephalopathy Pneumonia: Chest X-Ray + -

Cyanosis after Paroxysm Other: _____

Seizures (Focal or Generalized)

Does patient have history of Asthma/Bronchitis? Yes No

Is patient still coughing at final interview? Yes No Date: / /

Hospitalized at: _____

Admitted: / / *Discharged: / / # Days:

Physician Diagnosis: _____

**Please follow up on hospitalized infants until discharge.*

TREATMENT:

Were antibiotics given? Yes No

Azithromycin: Date Started: / / for Days
(Z-Pak, Zithromax)

Bactrim: Date Started: / / for Days
(TMP-SMX)

Clarithromycin: Date Started: / / for Days

Erythromycin: Date Started: / / for Days

Other: Date Started: / / for Days

Other: Date Started: / / for Days

OUTCOME: Survived Died Unknown

If Deceased, Date of Death: / /

Note: A Pertussis Death Worksheet must also be submitted to DSHS.

LABORATORY DATA: Was laboratory testing done? Yes No Unknown

LABORATORY: DSHS Other: _____ Phone: () - _____

PCR: Date specimen collected: / / Result: _____ Equivocal Pending

Culture: Date specimen collected: / / Result: _____ Equivocal Pending

Other: Date specimen collected: / / Result: _____ Equivocal Pending

Other: Date specimen collected: / / Result: _____ Equivocal Pending

**Note: A four-fold rise in titer level from acute specimen to convalescent sample may be considered positive serology for pertussis. IgG results from a single specimen, IgM, IgA and DFA results are not accepted as laboratory confirmation of a suspected pertussis case.*

Name: _____

Jurisdiction: _____

VACCINATION HISTORY: *CDC Objective: 90% of pertussis cases must have a vaccination history reported.*

VACCINATED: Yes No Unknown

**For cases <1, was the mother given Tdap, either at delivery or during pregnancy?* Yes No Date received: ____ / ____ / ____

1 DTP: ____ / ____ / ____ *Type: _____ Manufacturer: _____ Lot #: _____

2 DTP: ____ / ____ / ____ Type: _____ Manufacturer: _____ Lot #: _____

3 DTP: ____ / ____ / ____ Type: _____ Manufacturer: _____ Lot #: _____

4 DTP: ____ / ____ / ____ Type: _____ Manufacturer: _____ Lot #: _____

5 DTP: ____ / ____ / ____ Type: _____ Manufacturer: _____ Lot #: _____

6 Tdap: ____ / ____ / ____ Type: _____ Manufacturer: _____ Lot #: _____

**Use the following for vaccine type: DTaP, DTP, Tdap, Pediarix (DTaP/ IPV/Hep B), Pentacel (DTaP/IPV/ Hib), or Kinrix (DTaP/ IPV)*

Number of doses of pertussis-containing vaccine given: _____

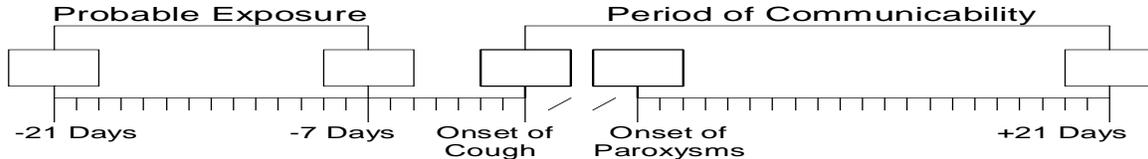
If not vaccinated or has <3 doses, indicate reason: Religious Exemption Medical Contraindication Evidence of Immunity Previous Disease - Lab Confirmed Previous Disease - MD Diagnosed Under Age Parental Refusal Unknown Other: _____

If vaccinated, please indicate:

How many doses of pertussis-containing vaccine were given 2 weeks or more before illness onset? _____

Date of Last Pertussis-Containing Vaccine Before Illness: _____

INFECTION TIMELINE: *Enter onset of cough. Count backwards and forwards to enter dates for probable exposure and communicable periods.*



SOURCE OF INFECTION: No exposure identified Close contact with a known or suspected case Household exposure

Name	Age	Cough Onset	How many doses of pertussis-containing vaccine has this suspected source received?	Phone	NBS Case No.
		/ /		() -	

Is case epidemiologically linked to a lab-confirmed case? Yes No Unknown NBS Case # _____

Where did this case acquire pertussis?: Day-care School College Work Home Doctor Office Hospital ER

Hospital Inpatient Hospital Outpatient Military Jail Church Travel Unknown Other: _____

Name(s) of Setting: _____

Has any travel occurred within the exposure period? Yes No Unknown If yes, list location: _____

Is case part of an outbreak*? Yes No Unknown If yes, list outbreak name: _____

**Outbreaks must be 3 or more cases in the same setting with cough onsets within a 3 week period*

Name: _____

Jurisdiction: _____

Did patient attend school/daycare? Yes No Unknown
If yes, which school/daycare: _____ Grade: _____ Teacher's name: _____

Transportation to school: Walk Carpool Car Bus# _____
Last date of attendance: ____/____/____ Date Returned: ____/____/____

After school care: _____ Other after school activities: _____ Where: _____

Did patient attend any of the following while symptomatic?: Sleepover Church activities Babysit Visit hospital patient

HOUSEHOLD CONTACTS: Were control activities initiated?: Yes No Unknown If no, explain: _____

Name	Relation to Case	Age	Vaccination HX	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Number of contacts recommended to receive antibiotics prophylaxis: _____

Antibiotic prophylaxis is recommended for household and high-risk contacts (infants, contacts of infants, immunocompromised)

**Investigations should be completed on all symptomatic contacts of confirmed or probable cases*

POSSIBLE SPREAD CONTACTS:

Setting: No Spread Day-care School College Work Home Doctor Office Hospital ER Hospital Inpatient
 Hospital Outpatient Military Jail Church Travel Unknown Other: _____

Name(s) of Setting: _____

Name	Relation to Case	Age	Vaccination HX	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Investigations should be completed on all contacts with symptoms*

PROVIDED INFORMATION TO PATIENT:

Vaccinations for Contacts/Household (most effective way to prevent pertussis) Transmission (person-person; by breathing in the bacteria)
 Daycare/school restriction, if applicable (may return after 5 days of antibiotics) Other: _____

CDC Objective: 90% of vaccine preventable cases must be investigated and reported to the CDC within 30 days of initial report.

Date Investigation Initiated: ____/____/____ Date Investigation Completed: ____/____/____ Date Reported to DSHS: ____/____/____

Investigator's Name: _____ Agency Name: _____ Phones: () - _____

Closed in NBS? Yes No

If confirmed or probable, notification submitted? Yes No

Name: _____

Jurisdiction: _____

COMMENTS/NOTES