Name (last, first):			Caseid:
Address:	City:	County:	Zip:
Reporting Provider:		Address:	Phone:

Pertussis Death Worksheet

----------Detach here and transmit only lower portion to CDC----------

Pertussis Death Worksheet

Data related to case:

1. Did the patient have underlying or previous medical conditions? ❑ Yes ❑ No ❑ Unknown

   If yes, please give details.

2. Was pulmonary hypertension a diagnosis in this patient? ❑ Yes ❑ No ❑ Unknown

3. Was patient hospitalized? ❑ Yes ❑ No
   If yes, please submit a copy of the hospital admission and discharge summary to DSHS

4. Where did the patient die? ❑Home ❑Hospital ❑En route to hospital
   ❑Other (Specify) _____

5. Was an autopsy performed? ❑ Yes ❑ No
   If yes, please submit a copy to DSHS.

6. Did the patient have a contact who had a cough illness? ❑ Yes ❑ No ❑ Unknown
   If yes, then who? _____

DOCTOR'S OFFICE/CLINIC/EMERGENCY DEPARTMENT VISITS

Please list the dates and name of all clinics or doctor's offices/emergency department visits made by the patient for this illness in chronological order.

Date of Visit	**Name and Address of Clinic, Doctor's Office, or Emergency Department visited**	**Telephone No.**

TEXAS Department of State Health Services

CLINICAL DATA

Please list the admission date(s) and discharge dates/transfer dates for this illness in chronological order.

Hospital name	Date of Admission	Date of Discharge/ transfer	Discharge Diagnosis

RESPIRATORY SUPPORT:.

	Yes/No	Date Started
Supplemental O_2 without intubation e.g. mask		
Supplemental O_2 via endotracheal intubation		
Continuous mechanical ventilation		
High Frequency Oscillatory Ventilation		
Extra Corporeal Membrane Oxygenation		

LABORATORY STUDIES: (Including tests obtained 30 days before onset of illness)

Specimen	Collection Date	Culture Result	PCR	DFA	ELISA
Nasopharyngeal - *B. pertussis*					
-RSV					
-Adenovirus					
-Influenza					
-Parainfluenza					
- Other (specify pathogen)					
Blood					
	Date	**Count**			
Total WBC Count (Initial)			% Lymphocyte		
Highest WBC Count			% Lymphocyte		

OTHER MEDICAL AND FAMILY INFORMATION

If the patient was <1 year of age:

7. What was the gestational age of the case? _____ weeks

What was the weight of the infant at birth? [lb oz] or [kg gm]

If the patient was <12 years of age:

8. What was the mother's age at time of patient's onset of coughing due to pertussis? _____ years

9. At the time of the patient's birth, did the mother have an immune-suppressed or a chronic underlying medical condition?

❑ Yes ❑ No ❑ Unknown

If yes, what is the name of the condition? [_____]

TEXAS Department of State Health Services

In the table below, list everyone who lives in the household, their date of birth, age, sex, the number of doses of pertussis containing vaccine received, and date of the last pertussis vaccine dose, smoking habits at home, and the presence of a cough illness during the 3-week period prior to the cough onset date in the patient. Please indicate if pertussis was the diagnosis for the cough illness, and if so, how pertussis was confirmed.

No.	Relationship to Patient	Date of Birth	Age	Sex	No. doses DTP/ DTaP/DT	Date of last dose	Smoking habits at home		Cough illness in family member during 3-week period prior to cough onset date in case-patient			
							Current smoker (Yes/No)	Avg. no. of cigarettes smoked daily	Cough (Yes/No)	Cough Onset Date	Pertussis diagnosis (Yes/No)	Confirmation method (Culture/ PCR / DFA/None)
1												
2												
3												
4												
5												
6												
7												
8												
9												

During the 3-week period prior to the cough onset, was the patient exposed to anyone **outside of the household** who was known to have a cough illness? ❑ Yes ❑ No ❑ Unknown

If yes, list all persons who had a cough illness and who may have exposed the patient, with the dates of cough onset in the table below.

No.	Relationship to Patient	Date of Birth	Age	Sex	No. doses DTP DTaP/DT vaccine*	Date of last Dose	Cough onset date	Date cough stopped	Pertussis Diagnosis	Confirmation Method (Culture/ PCR/DFA/ None)
1										
2										
3										
4										
5										

* Indicate type of vaccine if available