

Pertussis Case Track Record

FINAL STATUS:

- CONFIRMED PROBABLE
 RULED OUT/DROPPED

NBS PATIENT ID#: _____

Patient's Name: _____
Last First

Address: _____

City: _____ County: _____ Zip: _____

Region: _____ Phone:() _____

Parent/Guardian: _____

Physician: _____ Phone:() _____

Physician's Address: _____

Reported By: _____

Agency: _____

Phone:() _____

Date: ____/____/____

Report Given to: _____

Organization: _____

Phone: () _____

Date: ____/____/____

DEMOGRAPHICS:

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: Male Female Unknown

RACE: White Black Asian/Pacific Islander Native American Unknown Other: _____

HISPANIC: Yes No Unknown

CLINICAL DATA:

Cough - Onset Date: ____/____/____ *Final Cough Duration (total # of days)* _____

Paroxysmal Cough - Onset Date: ____/____/____

Inspiratory Whoop Vomiting after Paroxysm

Apnea (Exclude Cyanotic Episode) Cyanosis after Paroxysm

Pneumonia: Chest X-Ray + - Seizures (Focal or Generalized)

Acute Encephalopathy Other: _____

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

Hospitalized at: _____

Admitted: ____/____/____ Discharged: ____/____/____ # Days _____

Physician Diagnosis: _____

TREATMENT:

Were antibiotics given? Yes No

Erythromycin: Date Started: ____/____/____ for ____ Days

Cotrimoxazole: Date Started: ____/____/____ for ____ Days

Azithromycin: Date Started: ____/____/____ for ____ Days

Tetracycline: Date Started: ____/____/____ for ____ Days

Ampicillin: Date Started: ____/____/____ for ____ Days

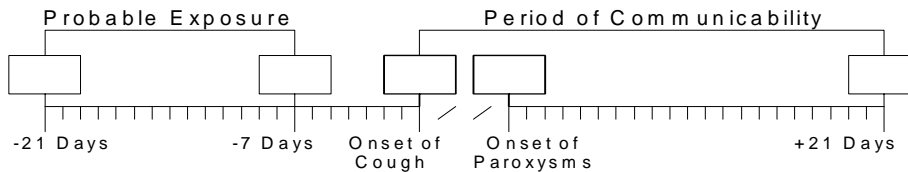
Other: _____ Date Started: ____/____/____ for ____ Days

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.

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



VACCINATION HISTORY:

VACCINATED: Yes No Unknown

1 DTP: ____/____/____ Type: DTP DTaP DTP-Hib DT Manufacturer: _____ Lot #: _____

2 DTP: ____/____/____ Type: DTP DTaP DTP-Hib DT Manufacturer: _____ Lot #: _____

3 DTP: ____/____/____ Type: DTP DTaP DTP-Hib DT Manufacturer: _____ Lot #: _____

4 DTP: ____/____/____ Type: DTP DTaP DTP-Hib DT Manufacturer: _____ Lot #: _____

5 DTP: ____/____/____ Type: DTP DTaP DTP-Hib DT Manufacturer: _____ Lot #: _____

If no, indicate reason: Religious exemption Medical Contraindication Evidence of immunity Previous Disease - Lab Confirmed
 Previous Disease - MD Diagnosed Under Age Parental Refusal Unknown Other: _____

Name: _____

LABORATORY DATA: Was laboratory testing done? Yes No Unknown

LABORATORY: DSHS Other: _____ Phone: () _____

Culture: Date specimen collected: ____/____/____ Result: _____

PCR: Date specimen collected: ____/____/____ Result: _____

DFA: Date specimen collected: ____/____/____ Result: _____

IgA IgG: Date of acute specimen: ____/____/____ Result: _____

Date of convalescent specimen: ____/____/____ Result: _____

Note: A four-fold rise in titer level from acute specimen to convalescent sample may be considered positive serology for pertussis. Results from a single specimen are not accepted as laboratory confirmation of a suspected pertussis case.

Results called to local investigator: Yes No Unknown

Person Contacted: _____ Date Called: ____/____/____ Initials: _____

SOURCE OF INFECTION: No exposure Identified Close contact with a known or suspected case.

Date of Contact	Name	Age	Address	Phone	Case No.
____/____/____	_____	____	_____	() _____	_____

Is case epidemiologically linked to a culture-confirmed case? Yes No Unknown

Where did this case acquire pertussis?: Day-care School College Work Home Dr Office Hospital ER
 Hospital Inpatient Hospital Outpatient Military Jail Church International Travel Unknown Other: _____

Name(s) of Setting: _____

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

Importation Class: Indigenous International Out-of-state Unknown If imported, from what country/state: _____

Is case traceable within 2 generations to international import? Yes No Unknown

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

Total number of contacts in any settings recommended antibiotics: _____

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
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____
_____	_____	____	_____	_____	_____

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

POSSIBLE SPREAD CONTACT:

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

Name (s) of Settings: _____

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

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

Investigator's Name: _____ Agency name: _____

Phone: () _____ Date Investigation Initiated: ____/____/____ Date Investigation Completed: ____/____/____

COMMENTS: