Pertussis

COUNTY

FOR STATE USE ONLY #

___/___/___ case report ☐ confirmed

___/___/___ interstate ☐ presumptive

Date / time investigation initiated: ____/____/____ _____:_____ ☐ am ☐ pm

CASE IDENTIFICATION

Name ______________________________ Phone(s) ______________________
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address ____
Street City County Zip

e-mail address ______________________________

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend______________

Name ______________________________ Phone(s) ______________________

Address ____ indicate home (H); work (W); message (M)
Street City Zip

SOURCES OF REPORT (*check all that apply*)

☐ Lab ☐ Infection Control Practitioner

☐ Physician ☐ ______________

Name ______________________

Phone ______________________

Date (first report) ___/___/___ Time ___:___ ☐ am ☐ pm

Primary M.D. (if different) ______________________

Phone OK to talk to patient? ☐

DEMOGRAPHICS

SEX ☐ female ☐ male

DATE OF BIRTH ____/____/____ (m d y)

or, if unknown, AGE ______

HISPANIC ☐ yes ☐ no ☐ unknown

RACE

☐ White ☐ American Indian

☐ Black ☐ Asian/Pacific Islander

☐ unknown ☐ refused to answer

☐ other ______________

Worksites/school/daycare______________________________

____

Occupations/grade______________________________

BASIS OF DIAGNOSIS

CLINICAL DATA

Earliest cough ONSET ____/____/____ (m d y)

Paroxysmal /spasmodic cough ONSET ____/____/____ (m d y)

whoop	☐ yes	☐ no	☐ unk
apnea	☐ yes	☐ no	☐ unk
cyanosis	☐ yes	☐ no	☐ unk
post-tussive vomiting	☐ yes	☐ no	☐ unk
cold-like symptoms	☐ yes	☐ no	☐ unk

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)

Hospitalized ☐ yes ☐ no

if yes, where______________________________

Admit date ____/____/____ (m d y)

Length of stay: ______ days

Died ☐ yes ____/____/____ (m d y) ☐ no ☐ unk

Cough at last interview: ☐ yes ☐ no ☐ unk

Duration of cough at final interview ________ days

Date of last interview ____/____/____ (m d y)

Antibiotics given ☐ yes ☐ no

1st antibiotic ☐ y ☐ n ______________________

start date ____/____/____ (m d y) # days taken_______

2nd antibiotic ☐ y ☐ n ______________________

start date ____/____/____ (m d y) # days taken_______

OTHER CLINICAL FINDINGS

chest x-ray for pneumonia
☐ pos ☐ neg ☐ not done
☐ unknown result

generalized or local seizures
☐ yes ☐ no ☐ unknown

acute encephalopathy
☐ yes ☐ no ☐ unknown

Notes:

LABORATORY DATA

date

Lab name ____

_____/_____/_____ (m d y) Culture ☐ pos. ☐ neg. ☐ not done ☐ unknown

_____/_____/_____ (m d y) PCR ☐ pos. ☐ neg. ☐ not done ☐ unknown

White count ≥25,000/µl ☐ yes ☐ no Lymphocytes ≥70% ☐ yes ☐ no

PATIENT'S NAME ▸ ____________________

EPI-LINKAGE

During the exposure period, was the patient

- ☐ associated with a known outbreak
- ☐ a close contact of a *confirmed* or *presumptive* case
  - was source case reported? ☐ yes ☐ not yet

Is the patient aware of anyone with a similar illness? ☐ yes ☐ no

Specifiy nature of contact: ☐ home ☐ day care/school ☐ other____________________

if yes to any question, give names, contact information, and other relevant details:

IMMUNIZATION HISTORY

Pertussis-containing vaccine received in past ☐ yes ☐ no ☐ unknown

if yes, complete table:

Vaccine	*Date*	*Provider/Phone*	*Verified* yes	*Verified* no
________________	____/____/____	______________________________	☐	☐
________________	____/____/____	______________________________	☐	☐
________________	____/____/____	______________________________	☐	☐
________________	____/____/____	______________________________	☐	☐
________________	____/____/____	______________________________	☐	☐

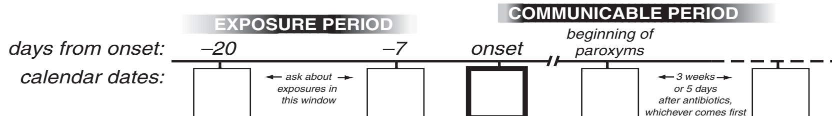
if not vaccinated, why not?

- ☐ age less than 2 months
- ☐ medical exemption
- ☐ religious objection
- ☐ "forgot"
- ☐ cost too much
- ☐ inconvenience
- ☐ concurrent illness
- ☐ other _______________

If available, provide details.

INFECTION TIMELINE

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



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case was already epi-linked.

Identify possible exposures in the 7-20 days prior to onset:

- ☐ no exposure identified
- a ☐ contact of *suspect* case
- b ☐ visit to doctor's office/clinic
- c ☐ visit to emergency room
- ☐ patient could not be interviewed
- d ☐ travel outside Oregon
- e ☐ other ________________

Specify details of any potential exposures, giving relevant dates, locations, contact persons, phone numbers, etc. Attach additional sheets if necessary.

PATIENT'S NAME ▸

Please check all applicable contacts
(if any, list below and do appropriate follow-up, using the Pertussis Contact Management Form on the next page)

A ☐ infant <1 year old B ☐ pregnant woman in 3rd trimester
C ☐ household contacts including family daycare or group daycare attendees where there is an infant <1 year of age or a pregnant woman in the 3rd trimester
D ☐ other ___________________________

Name of index case			Date completed mm/dd/yy	Completed by	Page No.
	Contact	**Contact**	**Contact**	**Contact**	**Contact**
Name					
DOB / Age	___/___/___ mm/dd/yy	___/___/___ mm/dd/yy	___/___/___ mm/dd/yy	___/___/___ mm/dd/yy	___/___/___ mm/dd/yy
Gender	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Relationship to case (family, daycare, preschool)					
Pregnant / EDC					
Date (mm/dd/yy) / time identified	____/____/____ __ ☐am ☐pm	____/____/____ __ ☐am ☐pm	____/____/____ __ ☐am ☐pm	____/____/____ __ ☐am ☐pm	____/____/____ __ ☐am ☐pm
Immunization status (# of doses)					
Occupation / school / daycare / preschool					
Signs and symptoms					
Date of swab (if done) mm/dd/yy and results	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Prophylaxis recommended Date (mm/dd/yy) Time	☐ Y ☐ N ____/____/____ __ ☐am ☐pm	☐ Y ☐ N ____/____/____ __ ☐am ☐pm	☐ Y ☐ N ____/____/____ __ ☐am ☐pm	☐ Y ☐ N ____/____/____ __ ☐am ☐pm	☐ Y ☐ N ____/____/____ __ ☐am ☐pm
Education provided Date (mm/dd/yy)	☐ Y ☐ N ____/____/____	☐ Y ☐ N ____/____/____	☐ Y ☐ N ____/____/____	☐ Y ☐ N ____/____/____	☐ Y ☐ N ____/____/____
Other					

COMMENTS

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

Date and time case report sent to OHS: ____/____/____ ____ ☐am ☐pm

Completed by ________________________________ Date ____________ Phone _________________ Investigation sent to OHS on ____/____/____

For use by the Oregon Public Health Division ONLY

ADDITIONAL DATA ELEMENTS IF PATIENT IS <12 MONTHS OLD

PATIENT'S NAME ▸ ______

COMPLICATIONS

- ☐ Hemorrhages in the CNS
- ☐ Pulmonary hyptertension (by echocardiogram or cardiac catheterization)
  - ☐ Mild (right ventricular 33-50% of systemic pressure)
  - ☐ Moderate (right ventricular 51-70% of systemic pressure)
  - ☐ Severe (right ventricular 71-100% of systemic pressure)
  - ☐ Critical (right ventriuclar >101% of systemic pressure
- ☐ Emphysema pulmonary
- ☐ Emphysema subcutaneous
- ☐ Pneumothorax
- ☐ Hernia (umbilical, inguinal)
- ☐ Rectal prolapse
- ☐ Discharged on oxygen
- ☐ Others

____

____

ICU ADMISSION

Length of stay______________________

RESPIRATORY SUPPORT

- ☐ Supplemental O^2 without intubation. Duration:______________________
- ☐ Supplemental O^2 with mechanical ventilation. Duration:______________________
- ☐ High frequency oscilatory ventilation. Duration:______________________
- ☐ Extra corporeal membrane oxygenation. Duration:______________________

OTHER CLINICAL DATA

- ☐ Pharmocologic blood pressure support (e.g. doparmine, dobutamine, epinepherine, neopinepherine)
- ☐ Exchange transfusion. Number of:______________________

OTHER MEDICAL AND FAMILY INFORMATION

Mother's age at infant's birth ______________

Gestational age of the infant ______________

Weight of the infant at birth ______________

Underlying or previous medical condition ______________________________