### DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>____________________________</td>
</tr>
<tr>
<td>County</td>
<td>____________</td>
</tr>
<tr>
<td>Address</td>
<td>______________________________________</td>
</tr>
<tr>
<td>Phone number</td>
<td>______________________ / ____________________</td>
</tr>
<tr>
<td></td>
<td>home (H), work (W), cell (C), message (M)</td>
</tr>
</tbody>
</table>

**ALTERNATIVE CONTACT**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>____________________________</td>
</tr>
<tr>
<td>Phone(s)</td>
<td>____________________________</td>
</tr>
</tbody>
</table>

### PROVIDERS, FACILITIES AND LABS

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporter</td>
<td>____________________________</td>
</tr>
<tr>
<td>Type (circle one)</td>
<td>PMD ELR MDx Lab ER HCP UC 2nd provider ICP</td>
</tr>
<tr>
<td></td>
<td>____________________________</td>
</tr>
<tr>
<td>Local epi_name</td>
<td>____________________________</td>
</tr>
<tr>
<td>Date report received by LHD</td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
<tr>
<td>LHD completion date</td>
<td><strong><strong>/</strong></strong>/____</td>
</tr>
</tbody>
</table>

### RACE (check all that apply)

- White
- Black
- Asian
- Pacific Islander
- American Indian/Alaska Native
- Unknown
- Refused
- Other

### HISPANIC

- Yes
- No

### 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)
CASE'S NAME

BASIS OF DIAGNOSIS, PERTUSSIS 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 _____/____/____

Comment:

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:

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

Reason not interviewed (choose one)
☐ refused ☐ physician interview ☐ medical record review

Y n u r
☐ ☐ ☐ ☐ contact of possible case
☐ ☐ ☐ ☐ places where exposed (check boxes to right)
☐ ☐ ☐ ☐ Travel outside the home area

When ____________________________

Where ____________________________

EXPOSURE PERIOD

Days from onset: ____________ calendar dates: _______ 21 _______ 7 _______

Communicable period

Beginning of paroxysms _______

3 weeks or 5 days after antibiotics, whichever comes first _______

Places where exposed
☐ daycare ☐ work ☐ other

☐ school ☐ college ☐ unknown

☐ doctor's office ☐ military

☐ hospital ward ☐ correctional facility

☐ hospital ER ☐ place of worship

☐ hosp.outpatient clinic ☐ international travel

☐ home ☐ other

Unknown:

FOLLOW-UP

Y n u r
☐ ☐ ☐ ☐ contact with infants
☐ ☐ ☐ ☐ contact with pregnant women in 3rd trimester

☐ ☐ ☐ ☐ all household contacts of case where there is infant or pregnant woman in 3rd trimester

☐ ☐ ☐ ☐ daycare contacts of case if there is infant or pregnant woman in 3rd trimester

☐ ☐ ☐ ☐ other contacts (pediatric healthcare workers, unimmunized contacts, other pregnant women, high risk contacts of suspect cases)

Settings where the case may have exposed others during infectious period

☐ daycare ☐ hospital ward ☐ >1 setting outside household ☐ college

☐ school ☐ hospital ER ☐ work ☐ military

☐ doctor's office ☐ hosp.outpatient clinic ☐ unknown ☐ correctional facility

☐ home ☐ place of worship

☐ international travel

☐ other

☐ no documented spread

☐ ☐ ☐ ☐ case educated about how to reduce disease transmission
If the case is an infant, and the contact is the mother, ask the following questions:

Have you ever been vaccinated with Tdap?  
☐ yes  ☐ no  ☐ mom not available for interview  ☐ unk

Were you vaccinated with Tdap during pregnancy with case infant?  
☐ yes  ☐ no  ☐ mom not available for interview  ☐ unk

If yes, what trimester  
☐ 1st  ☐ 2nd  ☐ 3rd  ☐ unk

If mother wasn't vaccinated during pregnancy with case infant, why not?  
☐ doesn't recall physician offering,  ☐ declined Tdap during pregnancy,  
☐ vaccinated following pregnancy  ☐ vaccinated prior to pregnancy  ☐ other: specify___________________________  ☐ unk

If you have access to ALERT, please print the vaccination history and staple to this form.
<table>
<thead>
<tr>
<th>CONTACT MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use this page for contacts other than the mother of infant cases. Add additional pages as necessary.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Contact 1</th>
<th>Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name (First, Middle [not initials] and Last)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phone number</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Address (street, city)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Address, (county, zip)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date of birth or years of age</strong></td>
<td><em><strong>/</strong></em>/___</td>
<td><em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td><strong>High risk</strong></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Yes  ☐ No</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>☐ Male  ☐ Female</td>
<td>☐ Male  ☐ Female</td>
</tr>
<tr>
<td><strong>Relation to case</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnant</strong></td>
<td>☐ Yes  ☐ No</td>
<td>☐ Yes  ☐ No</td>
</tr>
<tr>
<td><strong>Sick</strong></td>
<td>☐ Yes  ☐ No if yes, onset date <em><strong>/</strong></em>/___</td>
<td>☐ Yes  ☐ No if yes, onset date <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date identified</strong></td>
<td><em><strong>/</strong></em>/___</td>
<td><em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td><strong>Prophy recommended?</strong></td>
<td>☐ Yes  ☐ No  ☐ Already on antibiotics</td>
<td>☐ Yes  ☐ No  ☐ Already on antibiotics</td>
</tr>
<tr>
<td></td>
<td>Date recommended <em><strong>/</strong></em>/___</td>
<td>Date recommended <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td><strong>Education provided?</strong></td>
<td>☐ Yes  ☐ No if yes date provided <em><strong>/</strong></em>/___</td>
<td>☐ Yes  ☐ No if yes date provided <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td><strong>Immunization</strong></td>
<td>☐ Yes  ☐ No if yes date and vaccine type <em><strong>/</strong></em>/___</td>
<td>☐ Yes  ☐ No if yes date and vaccine type <em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td>(date and vaccine type)</td>
<td><em><strong>/</strong></em>/___</td>
<td><em><strong>/</strong></em>/___</td>
</tr>
<tr>
<td><strong>Date of swab (if done) and results</strong></td>
<td><em><strong>/</strong></em>/___  ☐ Indeterminate ☐ Positive ☐ Negative</td>
<td><em><strong>/</strong></em>/___  ☐ Indeterminate ☐ Positive ☐ Negative</td>
</tr>
<tr>
<td></td>
<td>☐ Not done  ☐ Unknown</td>
<td>☐ Not done  ☐ Unknown</td>
</tr>
</tbody>
</table>

* babysitter, coworker, daycare, father, friend, infant, medical, mother, mother (not biological), other household, preschool, school, sibling, unborn baby, other

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

** Comments **

ADMINISTRATION

**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
RACE AND ETHNICITY
How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?
Specify ______________________________________________________________________________

Which of the following best describes your racial or ethnic identity? Check all that apply.

- Amer Indian/Alaska Native
  - American Indian
  - Alaska Native
  - Canadian Inuit, Metis, First Nation
  - Indigenous Mexican, Central American, South American

- Asian
  - Asian Indian
  - Chinese
  - Filipino/a
  - Hmong
  - Japanese
  - Korean
  - Laotian
  - South Asian
  - Vietnamese
  - Other Asian

- Native Hawaiian/Pacific Islander
  - Guamanian
  - Chamorro
  - Micronesia/ Marshallese/Palaun (COFA)
  - Native Hawaiian
  - Samoan
  - Tongan
  - Other Pacific Islander

- Black or African American
  - African American
  - African (Black)
  - Caribbean (Black)
  - Other Black

- Middle Eastern
  - Northern African
  - Middle Eastern

- White
  - Eastern European
  - Slavic
  - Western European
  - Other White

- Other Categories
  - Other (please list)

- Other (please list)
  - Don't know
  - Don't want to answer

LANGUAGE
Do you speak a language other than English at home? If so
What language do you speak at home?
In which language do you feel most comfortable speaking with your doctor or nurse?
How well do you speak English?
Do you need an interpreter for us to communicate with you?
Are you deaf or do you have serious difficulty hearing?

DISABILITY.
Your answers to the questions help us find health and service differences among people with disabilities or limitations. Your answers are confidential.

For all ages:
Are you blind or do you have serious difficulty seeing even when wearing glasses?
Does a physical, mental or emotional condition limit your activities in any way?

For ages 5 and up:
Do you have serious difficulty walking or climbing stairs?
Do you have difficulty dressing or bathing?

Because of a physical, mental, or emotional condition, do you have serious difficulty:
  A. Concentrating, remembering or making decisions
  B. Doing errands alone such as visiting a doctor's office or shopping

For ages 15 and up:
  C. Eating
  D. Bathing or washing yourself