Pertussis

ORPHEUS ID

☐ confirmed
☐ presumptive
☐ not suspect
☐ no case

☐ pertussis
☐ parapertussis
☐ holmesii
☐ bronchiseptia

Name ______________________________ County ____________
LAST, first, initials (a.k.a.)

Address ______________________________
Street City

Phone number ______________ / ______________
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

E-mail ______________________________

ALTERNATE CONTACT

Name ______________________ Phone(s) ______________
LAST, first, initials home (H), work (W), cell (C), mes-

Special housing

☐ Nursing home/ Asst Living
☐ Homeless
☐ Prison/jail
☐ Foster home
☐ Hospital
☐ Nursing home
☐ Other institution
☐ Drug treatment/ shelter
☐ Women's shelter
☐ YES house
☐ Homeless shelter
☐ Job Corps
☐ Treatment center
☐ Chemawa Indian School
☐ Pacific Univ.
☐ No address on file

DEMOGRAPHICS

DOB ___/___/___ (m d y) if DOB unknown, AGE _____ Sex ☐ Female ☐ Male Preg ☐ Y ☐ N ☐ unk

Language ______________ Country of birth ______________ ☐ refugee

Worksites/school/day care center ______________ Occupation/grade ______________

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

HISPANIC or Latino/a
☐ Hispanic or Latino/a Central American
☐ Hispanic or Latino/a Mexican
☐ Hispanic or Latino/a

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

Native Hawaiian/ Pacific Islander
☐ Guamanian or Chamorro
☐ Micronesian
☐ Native Hawaiian
☐ Samoan
☐ Tongan
☐ Other Pacific Islander

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

Middle Eastern Northern African
☐ Northern African
☐ Middle Eastern

White
☐ Eastern European
☐ Slavic
☐ Western European
☐ Other White

Other Categories
☐ Other (please list)
____
☐ Don't know/Unknown
☐ Don't want to answer/ Decline

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
____
____
____

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
____
____
____

☐ Ok to contact patient (only list once)
Local epi_name ______________________________
Date report received by LHD ___/___/___ LHD completion date ___/___/___

Basis of diagnosis next page

CASE'S NAME

BASIS OF DIAGNOSIS

CLINIICAL 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 ☐ yes ☐ no ☐ refused ☐ unknown

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)

Deceased: ☐ yes ☐ no date of death ____/____/____

Cause: ______________________________
☐ related to disease ☐ unrelated to disease ☐ unk

Hospitalized: ☐ yes ☐ no ☐ unk
Hospital Name ______________________________

admit date ____/____/____ ☐ ICU
discharge date ____/____/____

Hospital Name ______________________________
admit date ____/____/____ ☐ ICU
discharge date ____/____/____

LABORATORY DATA ☐ None

Laboratory Name ______________________________
Collection date ____/____/____ Result date ____/____/____

Specimen type: ☐ NP swab ☐ NP aspirate
Test type: ☐ PCR ☐ Culture

Result: ☐ Indeterminate ☐ Positive ☐ Negative
☐ Not done ☐ Unknown

Laboratory Name ______________________________
Collection date ____/____/____ Result date ____/____/____

Specimen type: ☐ NP swab ☐ NP aspirate
Test type: ☐ PCR ☐ Culture

Result: ☐ Indeterminate ☐ Positive ☐ Negative
☐ Not done ☐ Unknown

TREATMENT

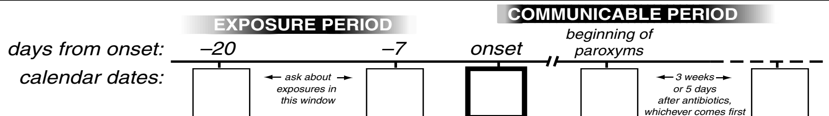
Drug name	Size/dose/frequency	Start date	End date
____________	____________	____/____/____	____/____/____
____________	____________	____/____/____	____/____/____
____________	____________	____/____/____	____/____/____

Comments:

CASE'S NAME ____________________

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 (specify) ____________________

Reason not interviewed (choose one)

☐ not indicated ☐ unable to reach ☐ out of jursdiction ☐ deceased

☐ refused ☐ physician interview ☐ medical record review

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

y	n	u	r	
☐	☐	☐	☐	contact of possible case
☐	☐	☐	☐	places where exposed (check boxes to right)
☐	☐	☐	☐	Travel outside the home area
				When ____________________
				Where ____________________
☐	☐	☐	☐	other risk, specify in notes

Places where exposed

☐ daycare ☐ work ☐ other

☐ school ☐ college ☐ unknown

☐ doctor's office ☐ military ☐ home

☐ hospital ward ☐ correctional facility

☐ hospital ER ☐ place of worship

☐ hosp.outpatient clinic ☐ international travel

FOLLOW-UP

y	n	u	r	
☐	☐	☐	☐	contact with infants
☐	☐	☐	☐	contact with pregnant women in 3rd trimester
☐	☐	☐	☐	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 ☐ place of worship

☐ school ☐ hospital ER ☐ work ☐ military ☐ international travel

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

☐ no documented spread

EPI-LINKAGE

y	n	u	
☐	☐	☐	associated with known outbreak
☐	☐	☐	close contact of another case

Nature

☐ coworker ☐ daycare ☐ other

☐ friend ☐ household

Epi-link ☐ household ☐ sporadic ☐ outbreak

Exposure type

☐ single ☐ multiple ☐ unknown

Exposure date and time ___/___/___ _______

Outbreak ID____________________

Generation ☐ 1 ☐ 2

IMMUNIZATION HISTORY

Up to date for pertussis ☐ yes ☐ no ☐ unk Received Tdap ☐ yes ☐ no ☐ unk

Source: Choose one

Vaccine	*Date*	ALERT / Provider / Verbal (Shot card) / Verbal (not verified)
___________	___/____/____	____________________
___________	___/____/____	____________________
___________	___/____/____	____________________

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

Vaccinated: ☐ yes ☐ no ☐ unk

if not vaccinated, why not?

☐ Religious exemption

☐ Medical contraindication

☐ Philosophical exemption

☐ Previous culture/MD confirmed

☐ Parental/patient refusal

☐ Too young

☐ Forgot

☐ Inconvenience

☐ Too expensive

☐ Concurrent illness

☐ Parent/patient unaware

☐ Vaccination records incomplete (unavailable)

☐ Other ☐ Unknown

CASE'S NAME

CONTACT MANAGEMENT

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 ☐ infant adopted or in foster care

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

Be sure to enter Tdap info below:

Date	Age	Vax name	Source: Choose one ALERT Provider Verbal (Shot card) Verbal (not verified)
____/____/____	_______________	___________________________	____
____/____/____	_______________	___________________________	____
____/____/____	_______________	___________________________	____

Use this page for contacts other than the mother of infant cases. Add additional pages as necessary

	Contact 1	Contact 2
Name (First, Middle [not initials] and Last)		
Phone number		
Address (street, city)		
Address, (county, zip)		
Date of birth or years of age	___/___/___	___/___/___
High risk	☐ Yes ☐ No	☐ Yes ☐ No
Sex	☐ Male ☐ Female	☐ Male ☐ Female
Race (fill in)		
Relation to case*		
Pregnant	☐ Yes ☐ No *if yes*, due date ___/___/__	☐ Yes ☐ No *if yes*, due date ___/___/__
Sick	☐ Yes ☐ No *if yes*, onset date ___/___/__	☐ Yes ☐ No *if yes*, onset date ___/___/__
Occupation		
Date identified	___/___/____	___/___/____
Prophy recommended?	☐ Yes ☐ No ☐ Already on antibiotics Date recommended ___/___/___	☐ Yes ☐ No ☐ Already on antibiotics Date recommended ___/___/___
Education provided?	☐ Yes ☐ No *if yes* date provided ___/___/_ __	☐ Yes ☐ No *if yes* date provided ___/___/___
Immunization** (date and vaccine type)	___/___/___	___/___/___
Date of swab (if done) and results	___/___/___ ☐ Indeterminate ☐ Positive ☐ Negative ☐ Not done ☐ Unknown	___/___/___ ☐ Indeterminate ☐ Positive ☐ Negative ☐ Not done ☐ Unknown

*babysitter, coworker, daycare, father, friend, infant, medical, mother, mother (not biological), other household, preschool, school, sibling, unborn baby, child, husband, spouse, wife, other
**If you have access to ALERT, please print the vaccination history and staple it to this form.

Comments

ADMINISTRATION

AUGUST 2018

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 ____/____/____