Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Pertussis

County

LHJ Use ID _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ID _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Cough** Cough onset date ___/___/___
☐	☐	☐	☐	**Vomiting due to cough (post-tussive)**
☐	☐	☐	☐	**Coughing in sudden bursts or fits (paroxysmal cough)** Onset date ___/___/___
☐	☐	☐	☐	**Whoop**
☐	☐	☐	☐	Cough at final interview Cough duration (days) at last interview ____ Date of final interview ___/___/___
☐	☐	☐	☐	**Cough lasting at least 2 weeks**
☐	☐	☐	☐	**Temporarily stops breathing (apnea)**
☐	☐	☐	☐	Episodes of turning blue (cyanosis)
☐	☐	☐	☐	Sore throat or pharyngitis
☐	☐	☐	☐	Runny nose (coryza)
☐	☐	☐	☐	Seizures new with disease

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Chronic lung disease

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	Pneumonia or pneumonitis X-ray confirmed: ☐Y ☐N ☐DK ☐NA
☐	☐	☐	☐	Acute encephalopathy
☐	☐	☐	☐	**Admitted to intensive care unit**

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Vaccination

Y	N	DK	NA	
☐	☐	☐	☐	Vaccine up to date for pertussis (if under age 15) Date last vaccine prior to illness: ___/___/___ # doses pertussis vaccine prior to illness: ____ Vaccine series not up to date reason: ☐ Religious exemption ☐ Medical contraindication ☐ Philosophical exemption ☐ Previous infection confirmed by laboratory ☐ Previous infection confirmed by physician ☐ Parental refusal ☐ Under age for vaccination ☐ Other: _____ ☐ Unknown

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	***B. pertussis* isolation (clinical specimen)**
☐	☐	☐	☐	***B. pertussis* PCR positive**

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to determine probable exposure and contagious periods

	Exposure period		onset	Contagious period*
Days from onset:	-20	-7		21+ days
Calendar dates:				

* If treated, ≤5 days after initiation of effective antibiotic therapy

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____
_____

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

☐ ☐ ☐ ☐ **Epidemiologically linked directly to a culture or PCR confirmed case**

☐ ☐ ☐ ☐ Contact with lab confirmed case
Age of person from whom this case contracted pertussis: _____ days/months/years

☐ ☐ ☐ ☐ Congregate living Type:
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

Y N DK NA

☐ ☐ ☐ ☐ Work or volunteer in health care setting during exposure period
Facility name: _____

☐ ☐ ☐ ☐ Visited health care setting during exposure period
Facility name: _____
Number of visits: _____ Date(s): ___/___/___

☐ ☐ ☐ ☐ Exposure setting identified:
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ College ☐ Work ☐ Military
☐ Correction facility ☐ Church
☐ International travel
☐ Other, specify: _____ ☐ Unknown

☐ **Patient could not be interviewed**

☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS/TREATMENT

Y N DK NA

☐ ☐ ☐ ☐ Antibiotics prescribed for this illness Name: _____
Date/time antibiotic treatment began: ___/___/___ _____ AM PM # days antibiotic actually taken: _____

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Work/volunteer in health care setting while contagious: Facility name: _____

☐ ☐ ☐ ☐ Visited health care setting while contagious
Facility name: _____
Number of visits: _____ Date(s): ___/___/___

☐ ☐ ☐ ☐ Face to face contact with newborns, unimmunized children, women > than 7 months pregnant or others at risk for severe complications

☐ ☐ ☐ ☐ Employed in child care or preschool

☐ ☐ ☐ ☐ Attends child care or preschool

☐ ☐ ☐ ☐ Household member or close contact in sensitive occupation or setting (HCW, child care, food)

☐ ☐ ☐ ☐ Documented transmission
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ Work ☐ College ☐ Military
☐ Correction facility ☐ Church
☐ International travel ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Prophylaxis of appropriate contacts recommended
Number of contacts recommended prophylaxis: _____
Number of contacts receiving prophylaxis: _____
Number of contacts completing prophylaxis: _____

☐ Exclude case from sensitive occupations or situations until 5 days of treatment complete or for 21 days

☐ Exclude susceptible close contacts under 7 years until 5 days of treatment completed or for 21 days

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

Pertussis: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered