



PERTUSSIS CASE REPORT

PATIENT DEMOGRAPHICS

Patient name—last	first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address—number, street			City	State	ZIP code
Telephone number Home () Work ()			Email:		

ETHNICITY (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown	RACE (check all that apply) <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <input type="checkbox"/> Asian: <i>Please specify:</i> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Thai <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Pacific Islander: <i>Please specify:</i> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____
--	--

Country of birth	Country of residence
------------------	----------------------

COMMON LHD TRACKING DATA

CMRID Number	IZB Case ID Number	WebCMR ID Number
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case
Case investigator completing form		Investigator telephone ()
		Investigator's jurisdiction

SIGNS AND SYMPTOMS

Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough onset date ____/____/____	Paroxysmal cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Whoop <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Post-tussive vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other symptoms		
Final interview date ____/____/____	Cough at final interview <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough duration at final interview (in days)	Diagnosis date ____/____/____	

Does case meet clinical criteria for further investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	DOES CASE MEET CDC/CSTE CLINICAL CRITERIA? (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized (≥24 hours) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Dates hospitalized ____/____/____ to ____/____/____	Total # days hosp ____ days	Facility	Chest x-ray for pneumonia <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not done <input type="checkbox"/> Unk
Intubated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days intubated	Seizures due to pertussis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pulmonary hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, describe:	If yes, date of death ____/____/____		

TREATMENT

1. Were antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	ABX 1 code	Date started ____/____/____	Number of days given	ANTIBIOTIC CODES: 1 = Erythromycin (includes pediazole) 2 = Trimethoprim/sulfamethoxazole (co- trimoxazole), i.g. bactrim/septra 3 = Azythromycin 4 = Tetracycline/doxycycline 5 = Amoxicillin/Penicillin /Ampicillin/Augmentin/Ceclor 6 = Other 7 = None 8 = Clarithromycin 9 = Unknown
2. Were antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	ABX 2 code	Date started ____/____/____	Number of days given	

LABORATORY TESTS

Any lab tests done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR LHD USE) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Culture performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Culture specimen date ____/____/____	Culture result (see codes) <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> S <input type="checkbox"/> U
PCR performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PCR specimen date ____/____/____	PCR Culture result (see codes) <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> S <input type="checkbox"/> U
WBC count performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	WBC specimen date ____/____/____	WBC results (please record percent lymphocytes)
Other lab tests performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other lab test specimen date ____/____/____	Specify other lab tests
		Other lab test results

VACCINATION/MEDICAL HISTORY

Ever received one or more doses of pertussis containing vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Number of doses prior to illness onset		
Dates of vaccination—Dose 1 ____/____/____	Dose 2 ____/____/____	Dose 3 ____/____/____	Dose 4 ____/____/____	Dose 5 ____/____/____	Dose 6 ____/____/____
Reason not vaccinated (check all that apply)					
1 <input type="checkbox"/> Personal Beliefs Exemption (PBE)		4 <input type="checkbox"/> Lab confirmation of previous disease		7 <input type="checkbox"/> Delay in starting series or between doses	
2 <input type="checkbox"/> Permanent Medical Exemption (PME)		5 <input type="checkbox"/> MD diagnosis of previous disease		8 <input type="checkbox"/> Other	
3 <input type="checkbox"/> Temporary Medical Exemption		6 <input type="checkbox"/> Under age for vaccination		9 <input type="checkbox"/> Unknown	
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			For infant cases (< 1 year old) ONLY: Name of hospital where case was born		
Epi-linked to a lab-confirmed case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case Name or Case ID		Outbreak related – if yes, please submit outbreak report form CDPH 8554 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Outbreak Name or Location	

PATIENT SETTING (EXPOSURE AND CONTACT)

Setting (check all that apply)

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital Ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional facility	15 <input type="checkbox"/> Other

Number of contacts for whom antibiotics were recommended: _____ Number of ill contacts: _____

EPIDEMIOLOGICAL EXPOSURE HISTORY – this section is optional. Please report all contacts meeting one of the case definitions listed below on a separate Case Report Form (CDPH 8258)

Close contact with person(s) with cough 21 days before cough onset? Yes No Unknown

	Name	Cough onset date	Relationship	Age (Years)	Same household
1		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

TIMELINE OF INFECTIOUSNESS AND STAGES OF COUGH – this section is optional and for local health department use only

WEEK	Exposure Period (typically 7-10 days, range 5-21 days)			Infectious Period (from onset of catarrhal stage until 5 days after antibiotic treatment or 3 weeks after cough onset)					
	-5 weeks	-4 weeks	-3 weeks	-2 weeks	-1 week	Cough onset date	+1 week	+2 weeks	+3 weeks
Enter dates									
Stages of illness	Usually no s/s of illness occur during this stage N.A.			Catarrhal Stage (typically 1-2 weeks)		Paroxysmal Stage (may last weeks to months)			

CASE CLASSIFICATION (FOR LHD USE) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown	CASE CLASSIFICATION (FOR STATE USE ONLY) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
--	---

REMARKS

PERTUSSIS DISEASE CASE CLASSIFICATION

Clinical case definition
A cough illness lasting at least 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or post-tussive vomiting, without other apparent cause (as reported by a health professional).

Case classification
Confirmed: A case with an acute cough illness of any duration with isolation of *B. pertussis* from a clinical specimen or detection of *B. pertussis* antigen by immunohistochemistry (IHC) methods (typically used for autopsied tissue only); or a case that meets the clinical case definition and is confirmed by positive PCR; or a case that meets the clinical case definition and is epidemiologically-linked directly to a case confirmed by either culture, PCR or IHC.
Probable: Meets the clinical case definition, is not laboratory confirmed by PCR culture, and is not epidemiologically linked to a laboratory-confirmed case.
Suspect: A case with an acute cough illness of any duration with positive PCR; or a case with an acute cough illness of any duration with at least one of the following: paroxysms of coughing, inspiratory "whoop," or post-tussive vomiting, that is epidemiologically-linked directly to a confirmed case.