# Pertussis

ORPHEUS ID

☐ confirmed ☐ pertussis
☐ presumptive ☐ parapertussis
☐ suspect ☐ holmesii
☐ no case ☐ bronchiseptica

Name _____ County_____

Address _____ Special housing _____

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

ALTERNATIVE CONTACT

Name _____ Phone(s) _____

## DEMOGRAPHICS

DOB ____/____/____

if DOB unknown, AGE _____

Sex ☐ Female ☐ Male
Pregnant ☐ Yes ☐ No ☐ Unk

Language _____

Country of birth _____

Worksites/school/day care center
_____

Occupation/grade
_____

RACE (*check all that apply*)
☐ White
☐ Black
☐ Asian
☐ Pacific Islander
☐ American Indian/Alaska Native
☐ Unknown
☐ Refused
☐ Other_____

HISPANIC
☐ Yes ☐ No
☐ Unknown ☐ Declined

## PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)

☐_____ PMD ELR
name and phone number MDx Lab
ER HCP
UC 2nd provider
ICP

☐_____ PMD ELR
name and phone number MDx Lab
ER HCP
UC 2nd provider
ICP

☐ Ok to contact patient

Local epi_name _____
Date report received by LHD ____/____/____
LHD completion date ____/____/____

## 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 ☐ 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 ____/____/____

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

**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

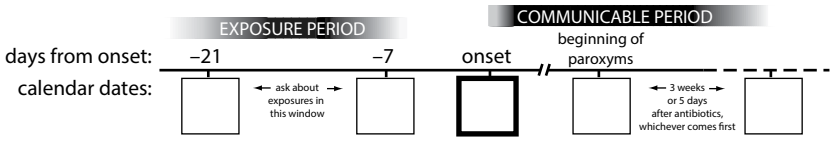
**TREATMENT**

| 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 jursdiction ☐ deceased
☐ 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*_____ |
| ☐ | ☐ | ☐ | ☐ | other risk |

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 | | |

## 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 | ☐ place of worship |
| ☐ school | ☐ hospital ER | ☐ work | ☐ military | ☐ international travel |
| ☐ doctor's office | ☐ hosp.outpatient clinic | ☐ unknown | ☐ correctional facility | ☐ other |
| | | | | ☐ no documented spread |

☐ ☐ ☐ ☐ case educated about how to reduce disease transmission

CASE'S NAME

## EPI-LINKAGE

y n u
☐ ☐ ☐ associated with known outbreak
☐ ☐ ☐ close contact of another case
Nature
☐ coworker ☐ daycare
☐ friend ☐ household
☐ infant ☐ unborn baby
☐ ☐ ☐ has case been reported

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

| *Vaccine* | *Date* | *Source: Choose one* 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 (unavailalbe)
☐ Other
☐ Unknown

## 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) |
|---|---|---|---|
| ___/___/___ | _____ | _____ | _____ |
| ___/___/___ | _____ | _____ | _____ |
| ___/___/___ | _____ | _____ | _____ |

COMMENTS

CASE'S NAME

## CONTACT MANAGEMENT

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 |
| 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 ☐ Unknownn |

*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



*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

Print Form Clear Form

Orpheus ID

## RACE, ETHNICITY, LANGUAGE, AND DISABILITY (REALD)

### 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

**Hispanic or Latinx**
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Puerto Rican
- ☐ Other Hispanic or Latinx

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

If you selected more than one racial or ethnic identity, circle the one that **best** represents your racial or ethnic identity. If you have **more than one** primary racial or ethnic identity please check here. ☐.

**Native Hawaiian/ Pacific Islander**
- ☐ Guamanian
- ☐ Chamorro
- ☐ Micronesian/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**
- ☐ Northern African
- ☐ Middle Eastern

**White**
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

**Other Categories**
- ☐ 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 to speak at home?
In which language you feel most comfortable speaking with your doctor or nurse?
How well do you speak English? Pick one
Do you need an interpreter for us to communicate with you? Interpreter needed
Are you deaf or do you have serious difficulty hearing? Deaf/HH

### 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? Vision

Does a physical, mental or emotional condition limit your activities in any way? Limitations

**For ages 5 and up:**

Do you have serious difficulty walking or climbing stairs? Declined
Do you have difficulty dressing or bathing? Self-care
Because of a physical, mental, or emotional condition, do you have serious difficulty:
A. Concentrating, remembering or making decisions? Declined

**For ages 15 and up:**

B. Doing errands alone such as visiting a doctor's office or shopping? Errands