Georgia Department of Public Health

Enhanced Pertussis Surveillance Form

SendSS ID: _____ □ Final

Form Complete □ Yes □ No □Corrected

PATIENT DEMOGRAPHICS

Patient name: Last, First M.I.	Date of birth (mm/dd/yy): ____/____/____	Age *(enter age and check one):* _____ □ Days □ Weeks □ Months □ Years	Gender: □ Male □ Female

Address: Number, Street	City:	State:	ZIP code:	County:

Telephone number: Home ( ) – Work ( ) – Country of birth:

Ethnicity (check one):
□ Hispanic/Latino
□ Non-Hispanic/Latino
□ Unknown

Race (check all that apply):
□ Black/African-American
□ Native American/Alaskan Native
□ White
□ Asian /Pacific Islander
□ Multiracial
□ Other (please specify)_____
□ Unknown

TRACKING DATA

Medical record no. or client no.: State Case ID ***(For state use only):***

Date reported to health department: ____/____/____ Case investigator completing form:

Date investigation started: ____/____/____ Organization: Investigator phone: ( ) –

Event Date: ____/____/____ Person/Clinic Reporting: Reporter telephone: ( ) –

Event Type: □ Onset Date □Diagnosis Date □Lab Test Date □Report Date (County) □Report Date (State) □Unknown

SIGNS AND SYMPTOMS

Any cough? □ Yes □ No □ Unknown	Cough onset date ____/____/____	Cough 14 days after cough onset? □ Yes □ No □ Unknown	Paroxysmal cough? □ Yes □ No □ Unknown
Whoop? □ Yes □ No □ Unknown	Posttusive vomiting? □ Yes □ No □ Unknown	Apnea? □ Yes □ No □ Unknown	Cyanosis? □ Yes □ No □ Unknown

Fever? □ Yes, Patient report □ Yes, Provider report □Yes, both reported □No □ Unknown **If, yes** highest temperature: ___ ___ ___ . ___◦F (unknown=999.9)

Fever onset was _____ cough onset □ Before □ After □ Same day as □ Unknown

Number of physician visits prior to diagnosis _____ □ Unknown	Duration of cough at final interview (days) _____	Final interview date ____/____/____	Cough at final interview □ Yes □ No □ Unknown

Reason for insufficient **Infant** Cough: □ Died (<14 days after onset) □Cough inhibited (medical intervention) □Lost to follow-up □Resolved (<14 day duration) □Other □Unknown

DOES CASE MEET CLINICAL CRITERIA □Yes □No □Unknown ***(For state use only)***

COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized? □ Yes □ No □ Unknown	Admission date ____/____/____	Discharge date ____/____/____	Number of days hospitalized ____	Facility: Died? □Yes □ No □Unknown Date of death ____/____/____ **If died, complete and attach pertussis death worksheet**
X-ray for pneumonia? □ Not done □ Pos □ Neg □ Unknown	Seizures? □ Yes □ No □ Unknown	Acute encephalopathy? □ Yes □ No □ Unknown		

TREATMENT

Antibiotics given? □ Yes □ No □ Unknown

1st antibiotic start date ___/___/___

1st antibiotic received:
□ Erythromycin (1)
□ Clarithromycin/Azithro.(2)
□ Tetracycline/Doxy. (3)
□ Cotrimoxazole (4)
□Unknown (9)
□ Amoxicillin/Penicillin/ Ampicillin/Augmentin/ Ceclor/Cefixime (5)
□ Other (6)

2nd antibiotic received: __ (# from 1st antibiotic received list)

No. of days 1st antibiotic actually taken _____

2nd antibiotic start date ___/___/___

No. of days 2nd antibiotic actually taken _____

LABORATORY TESTS

Was laboratory testing for pertussis done? □ Yes □ No □ Unknown

Case lab confirmed ***(For state use only)*** □ Yes □ No □ Unknown

Isolate/Specimen Available: □ Yes □ No

	Result	Date specimen taken	Lab name
Culture	_____	____/____/____	_____
PCR	_____	____/____/____	_____
IgA	_____	____/____/____	_____
IgG	_____	____/____/____	_____
IgM	_____	____/____/____	_____
DFA	_____	____/____/____	_____

Co-infection with other *Bordetella species*?
□ No known co-infection
□ *B. parapertussis*
□ *B. bronchiseptica*
□ *B. holmesii*

Ship Date to GPHL: ____/____/____

Expected date to CDC: ___/___/___

Ship Date to CDC: ____/____/____

Result Codes: P:Positive X:Not done N:Negative I:Indeterminate E:Pending U:Unknown S:*B.parapertussis* B:*B.bronchiseptica* H:*B.holmseii*

Comments:

VACCINATION HISTORY

Vaccinated? (Received any doses of pertussis-containing vaccines)
□ Yes □ No □ Unknown

No. doses of pertussis-containing vaccine received prior to illness onset? _____

Dose	Vaccination date	Vaccine type*	Vaccine manufacturer†	Lot number
Dose 1	___/___/___			
Dose 2	___/___/___			
Dose 3	___/___/___			
Dose 4	___/___/___			
Dose 5	___/___/___			
Dose 6	___/___/___			

***Vaccine type codes:**

W:DTP	P: Pertussis Only	K: DTaP-IPV (Kinrex)
A: DTap	B: DTP-Hib-HepB	O: Other
H: DTaP-Hib	X: Tdap (Adacel, Boostrix)	U: Unknown
D: DT or Td	V: DTaP-IPV-HepB (Pediarix)	C: Pertussis vaccine (unspecified)
T: DTP-Hib	N: DTaP-IPV-Hib (Pentacel)	

†Vaccine manufacturer codes:

C: Sanofi Pasteur	N: North American Vaccine
L: Wyeth	O: Other
S: Glaxo Smith Kline	U: Unknown
M: Mass. Health Dept	
I: Michigan Health Dept	

Reason patient not **age-appropriately** vaccinated :

□ Religious exemption □ Previous culture/MD confirmed pertussis □ Unknown
□ Medical contraindication □ Parental/Patient refusal □ Forgot □ Other
□ Philosophical exemption □ Too Young □ Inconvenience □ Concurrent Illness
□ Too expensive □ Unaware

EPIDEMIOLOGIC INFORMATION

Case Report Status: □ Confirmed □ Probable *(For state use only)*

Outbreak related? □ Yes □ No □ Unknown
Outbreak name or location:

Epi-linked? □ Yes □ No □ Unknown
Name of Epi-linked case: _____
SendSS ID of Epi-linked case: _____

Previous Pertussis Diagnosis? If yes, year:
□ Yes □ No □ Unknown ___ ___ ___ ___
Previous State Case ID: _____

Employed at or attends school? □ Yes □ No □ Unknown
Employed at or attend daycare? □ Yes □ No □ Unknown
Is patient incarcerated? □ Yes □ No □ Unknown
Is patient instutionalized? □ Yes □ No □ Unknown
Pregnancy status at cough onset:
□ Pregnant* □ Postpartum □ Neither □Unknown
***If pregnant:**
Expected due date ___/___/___ Weeks of pregnancy ____

Is patient a healthcare worker?
□ Yes, w/ direct patient contact
□ Yes, w/ **no** direct patient contact
□ No
□ Unknown

PATIENT SETTING (EXPOSURE AND CONTACT)

Transmission setting (Where did this case acquire pertussis?)

□ Daycare (1) □ Hospital ER (5) □ Unknown (9) □ Place of worship (13)
□ School (2) □ Outpatient clinic (6) □ College (10) □ International travel (14)
□ Doctor's Office (3) □ Home (7) □ Military (11) □ Other (15)
□ Hospital Ward (4) □ Work (8) □ Correctional facility (12)

Setting of further documented spread from case (outside of household) **(use number codes from transmission setting question)**
(no documented spread = 16)

Number of residents in case's household: _____

Number of contacts recommended antibiotics: _____
Number of contacts completing antibiotics: _____

Answer ONLY IF patient <12 months old

Suspected source of infection (if case < 1 year, is another person with suspected pertussis known?) □ Yes □ No □ Unknown

Source's relationship to case

□ Mother □ Brother □ Grandparent □ Other □ Cousin
□ Father □ Neighbor □ Friend □ Aunt □ Sibling N/S
□ Sister □ Daycare □ Baby Sitter □ Uncle □ Unknown

Source's current age: _____

Infant gestational age at birth: _____
Mother's age at infant birth: _____
Weight of infant at birth:
lb oz

MATERNAL TDAP INFORMATION - ONLY FOR MOTHERS OF INFANTS < 12 MONTHS OLD

Has mom ever been vaccinated with Tdap?
□ Yes □ No □ Mom N/A □ Unknown

Dose	Tdap Vaccination date	Source*
Dose 1	____/____/____ □Unk	
Dose 2	____/____/____ □Unk	
Dose 3	____/____/____ □Unk	
Dose 4	____/____/____ □Unk	
Dose 5	____/____/____ □Unk	

*Souce codes: 1: Medical Provider
2: Immunization registry 3: Verbal Report (shot card)
4: Verbal report (non-verified)

Was Tdap vaccine given to mom *during* pregnacy with [case infant]?
□ Yes □ No
□ Mom N/A for interview
□ Infant adopted/ in foster care
□ Unknown

If mom **was vaccinated** with Tdap *during* pregnancy with [case infant], during which trimester was vaccine given?
□ 1st trimester (1-12 wks) □ Not vaccinated during
□ 2nd trimester (13-27 wks) pregnancy with [case infant]
□ 3rd trimester (28-42 wks) □ Unknown

If mom **was not vaccinated** *during* pregnancy with [case infant], why not?
□ Tdap not offered by physician □ Declined Tdap
□ Vaccinated prior to pregnancy □ Other:_____
□ Vaccinated after pregnancy □ Unknown