Georgia Department of Public Health

Pertussis Reporting and Case Investigation Form

PATIENT DEMOGRAPHICS

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

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

Telephone number:

Home ( ) – Work ( ) –

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

Country of birth:

TRACKING DATA

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

Date reported to health department (mm/dd/yy):	Date investigation started:	Person/clinician reporting:	Reporter telephone:
____/____/____	____/____/____		( ) –

Case investigator completing form:	Investigator telephone:	Investigator's organization:
	( ) –	

Is this case epi-linked to another confirmed or probable case? □ Yes □ No □ Unknown

SIGNS AND SYMPTOMS

Any cough?	Cough onset date	Cough 14 days after cough onset?	Paroxysmal cough?
□ Yes □ No □ Unknown	____/____/____	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown

Whoop?	Post-tusive vomiting?	Apnea?	
□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	

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

Duration of cough at final interview (days)	DOES CASE MEET CLINICAL CRITERIA
_____ days	□ Yes □ No □ Unknown ***(For state use only)***

COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized?	Admission date	Discharge date	No. of days hospitalized	Facility
□ Yes □ No □ Unknown	____/____/____	____/____/____	_____days	

X-ray for pneumonia?	Seizures?	Acute encephalopathy?
□ Pos □ Neg □ Not done □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown

Died?	Date of death	
□ Yes □ No □ Unknown	____/____/____	**If case died, please complete and attach pertussis death worksheet**

TREATMENT

Antibiotics given?	1st antibiotic received		Date 1st antibiotic started
□ Yes □ No □ Unknown	□ Erythromycin (1) □ Clarithromycin/Azithromycin (2) □ Tetracycline/Doxycycline (3) □ Cotrimoxazole (4)	□ Amoxicillin/Penicillin/Ampicillin/ Augmentin/Ceclor/Cefixime (5) □ Other (6) □ Unknown (9)	____/____/____

No. of days 1st antibiotic actually taken	2nd antibiotic received	Date 2nd antibiotic started	No. of days 2nd antibiotic actually taken
_____ days	See choices for 1st antibiotic received _____	____/____/____	_____ days

LABORATORY TESTS

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

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

	Result	Date specimen taken	Lab name
Culture	_____	____/____/____	_____
PCR	_____	____/____/____	_____
Serology 1	_____	____/____/____	_____
Serology 2	_____	____/____/____	_____
DFA	_____	____/____/____	_____

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

VACCINATION HISTORY

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

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

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

(If available) Reason for inadequate vaccination coverage (check all that apply)
□ Religious exemption
□ Medical contraindication
□ Philosophical exemption
□ Previous culture/MD confirmed pertussis
□ Parental refusal
□ Age < 7 months
□ Other
□ Unknown

EPIDEMIOLOGIC INFORMATION

Epi-linked?
□ Yes □ No □ Unknown

Outbreak related?
□ Yes □ No □ Unknown

Outbreak name or location

Employed at or attends daycare ?
□ Yes □ No □ Unknown

Employed at or attends school?
□ Yes □ No □ Unknown

PATIENT SETTING (EXPOSURE AND CONTACT)

Transmission setting (Where did this case acquire pertussis?)
□ Daycare (1)
□ School (2)
□ Doctor's Office (3)
□ Hospital Ward (4)
□ Hospital ER (5)
□ Outpatient clinic (6)
□ Home (7)
□ Work (8)
□ Unknown (9)
□ College (10)
□ Military (11)
□ Correctional facility (12)
□ Church (13)
□ International travel (14)
□ Other (15)

Number of contacts recommended antibiotics

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

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

Source's relationship to case (if patient <12 months old)
□ Mother □ Brother □ Grandparent
□ Father □ Friend □ Neighbor □ Daycare
□ Sister □ Other □ Baby Sitter □ Unknown

Source's current age (if patient < 12 months old) _____

Mother's age at infant birth _____

Number of residents in case household(s) _____

Weight of infant at birth (if patient <12 months old) _____ lb _____oz

Comments: