

# PERTUSSIS CASE REPORT



## PATIENT DEMOGRAPHICS

Patient's name (last, first, middle initial)			DOB (month/day/year) / /		VCMR ID	
Address (number and street)		Apt #	City/town	State	Zip code	County
Phone number Home ( ) Cell/Work( )			Country of birth <input type="checkbox"/> USA <input type="checkbox"/> Other:		Date of arrival to USA (if not born in USA) / /	
Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk			Gender (check one) <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other (specify) <input type="checkbox"/> Unk			
Race (check all that apply)						
<input type="checkbox"/> Black/African-American		<input type="checkbox"/> Asian (please specify)		<input type="checkbox"/> Pacific Islander (please specify)		
<input type="checkbox"/> Native American/Alaskan Native		<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Native Hawaiian		
<input type="checkbox"/> White		<input type="checkbox"/> Hmong		<input type="checkbox"/> Guamanian		
<input type="checkbox"/> Unknown		<input type="checkbox"/> Cambodian		<input type="checkbox"/> Samoan		
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Japanese		<input type="checkbox"/> Other Pacific Islander: _____		
<input type="checkbox"/> Chinese		<input type="checkbox"/> Korean				
<input type="checkbox"/> Filipino		<input type="checkbox"/> Laotian				
Occupation		Setting (check all that apply): <input type="checkbox"/> Health Care <input type="checkbox"/> Day Care <input type="checkbox"/> School <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other, specify:			Primary Language	

## CLINICAL SIGNS AND SYMPTOMS AND COURSE OF ILLNESS *\*If fatal, notify VPDC Program immediately.*

Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Cough onset date / /	Paroxysmal cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Whoop <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	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"/> Unk		Cyanosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Highest fever: °F/°C / /	Symptom onset date (if no cough) / /		
Other Symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, describe:		Cough duration at end of investigation <input type="checkbox"/> <14 days <input type="checkbox"/> ≥ 14 days <input type="checkbox"/> Unk			
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If pregnant, estimated date of delivery: / /	Hospitalized (≥24 hours) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Dates hospitalized: / / to / /	Total # days hosp. _____ days		
Hospital name		Patient in ICU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Days in ICU	Intubated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Days intubated	Seizures due to pertussis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
Receive exchange transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Receive ECMO <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Chest x-ray for pneumonia <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done		Died* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date of death / /
Were appropriate antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date started antibiotics / /		Antibiotic type: <input type="checkbox"/> Azithromycin <input type="checkbox"/> Clarithromycin <input type="checkbox"/> Erythromycin (includes pediazole) <input type="checkbox"/> Trimethoprim/sulfamethoxazole (cotrimoxazole), i.e., bactrim/septra <input type="checkbox"/> Other: _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown			

## FOR INFANTS <12 MONTHS OF AGE

Mother's name (last, first, middle initial)		Mother's DOB (mm/dd/yyyy) / /
Prenatal care provider name (Clinician and/or Practice) <small>If mother received prenatal care at more than one provider, document provider(s) who saw mother closest to 27-36 weeks gestation.</small>		Prenatal care provider location (street, city, state, zip)
Prenatal care provider phone		
Did mother receive Tdap during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No-mother declined <input type="checkbox"/> No-never recommended <input type="checkbox"/> No-rec'd at hospital after delivery <input type="checkbox"/> No-Other, why: _____ <input type="checkbox"/> Unk		
If yes, what trimester during pregnancy or postpartum did the mother receive Tdap? <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> Postpartum/after delivery <input type="checkbox"/> Unk		
Where did mother receive Tdap during this pregnancy? <input type="checkbox"/> Prenatal care provider's office <input type="checkbox"/> Pharmacy <input type="checkbox"/> Local health department <input type="checkbox"/> Other medical office <input type="checkbox"/> Hospital, postpartum		
If the mother did not receive the Tdap at the prenatal care provider's office, what is the name and phone number of the facility where she got the Tdap?		
Facility name		Facility phone

## VACCINATION / MEDICAL HISTORY

Has the patient ever received pertussis vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Number of doses prior to illness onset:	Type of vaccine for last dose <input type="checkbox"/> Tdap <input type="checkbox"/> DTaP <input type="checkbox"/> DTP	Date of last dose / /
Reason not vaccinated (check all that apply): <input type="checkbox"/> Personal Beliefs Exemption (PBE) <input type="checkbox"/> Permanent Medical Exemption (PME) <input type="checkbox"/> Temporary Medical Exemption <input type="checkbox"/> Under age for vaccination <input type="checkbox"/> Delay in starting series or between doses <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____				

## PLEASE ENTER DOSE INFORMATION FOR ENTIRE SERIES FOR INFANTS <12 MONTHS OF AGE - (other ages optional)

#1: / /	#2: / /	#3: / /	#4: / /	#5: / /	#6: / /
<input type="checkbox"/> Date Unk	<input type="checkbox"/> Date Unk	<input type="checkbox"/> Date Unk	<input type="checkbox"/> Date Unk	<input type="checkbox"/> Date Unk	<input type="checkbox"/> Date Unk

**LABORATORY INFORMATION**

**CASE LAB CONFIRMED (FOR VPDC USE)**  Yes  No  Unknown

Culture performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Culture specimen date / /	Culture result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Unk
Polymerase chain reaction (PCR) performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PCR specimen date / /	PCR result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Unk
Other pertussis lab tests performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other test specimen date / /	Specify other lab tests Other lab test results

**EPIDEMIOLOGIC INFORMATION**

Contact to an infant <1 year of age? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Contact to a pregnant woman? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other sensitive occupation/setting? Describe: <input type="checkbox"/> Child care <input type="checkbox"/> Healthcare <input type="checkbox"/> Other
Epi-linked to a lab-confirmed case <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case name <u>and</u> vCMR ID	Outbreak-related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Outbreak number & location

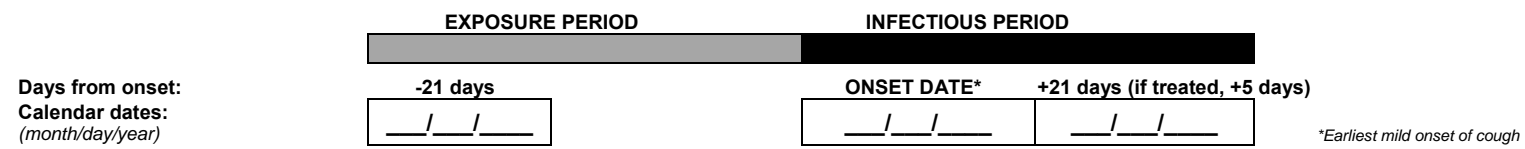
**CONTACTS**

Cough	Name	DOB	Age	Same household	Earliest mild cough onset date	Duration (days)	Signs and Symptoms	PCR (+)	Rx date	Rx Name
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		<input type="checkbox"/> Paroxysms <input type="checkbox"/> Post-tussive vomit <input type="checkbox"/> Whoop <input type="checkbox"/> Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		<input type="checkbox"/> Paroxysms <input type="checkbox"/> Post-tussive vomit <input type="checkbox"/> Whoop <input type="checkbox"/> Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		<input type="checkbox"/> Paroxysms <input type="checkbox"/> Post-tussive vomit <input type="checkbox"/> Whoop <input type="checkbox"/> Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		<input type="checkbox"/> Paroxysms <input type="checkbox"/> Post-tussive vomit <input type="checkbox"/> Whoop <input type="checkbox"/> Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		<input type="checkbox"/> Paroxysms <input type="checkbox"/> Post-tussive vomit <input type="checkbox"/> Whoop <input type="checkbox"/> Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	
<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /		<input type="checkbox"/> Paroxysms <input type="checkbox"/> Post-tussive vomit <input type="checkbox"/> Whoop <input type="checkbox"/> Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /	

**INFECTION TIMELINE**

**Incubation period:** 7-21 days.  
**Infectious period:** Up to 21 days after the onset of the earliest mild cough. If treated, only 5 days.  
**Post-exposure prophylaxis:** See B-73.

*Enter date of earliest mild cough onset in onset box  
 Count backward to determine probable exposure period and count forward to determine infectious period.*



**COMMON VPDC TRACKING DATA**

Date reported / /	Date investigation started / /	Person/clinician reporting case	Reporter telephone ( )
Investigator's name		Investigator's telephone ( )	Health District

**CASE CLASSIFICATION (FOR VPDC USE)**  Confirmed  Probable  Suspect  Not a case  Unknown

**2014 CASE DEFINITION**

**Clinical case definition:** In the absence of a more likely diagnosis a cough illness lasting ≥ 2 weeks with one of the following symptoms:

- Paroxysm of coughing, **OR** · Inspiratory "whoop," **OR**
- Post-tussive vomiting, **OR** · Apnea (with or without cyanosis) (FOR INFANTS AGED <1 YEAR ONLY)

**Case classification**

**Confirmed:** 1) An acute cough illness of any duration with isolation of *B. pertussis* from a clinical specimen **OR**

2) A case that meets the clinical case definition and is confirmed by detection of *B. pertussis*-specific nucleic acid by polymerase chain reaction (PCR) **OR**

3) A case that meets the clinical case definition and is epidemiologically-linked directly to a laboratory-confirmed case of pertussis.

**Probable:** 1) A case that meets the clinical case definition and is not laboratory-confirmed with culture or PCR and is not epidemiologically-linked directly to a confirmed case. **OR**

FOR INFANTS AGED <1 YEAR ONLY

2) Acute cough illness of any duration, with at least one of the following: (paroxysms of coughing, inspiratory "whoop", post-tussive vomiting, or apnea (with or without cyanosis) **AND** PCR positive for pertussis or contact to a laboratory-confirmed case of pertussis.

**Suspect:** 1) An acute cough illness of any duration with detection of *B. pertussis*-specific nucleic acid by PCR **OR**

2) 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.