Pertussis Assessment Form

In lieu of a *Confidential Morbidity Report*, please complete this form when you have a patient with possible pertussis. Have the form completed by staff. Public Health is exempt from HIPAA regulations and is not required to secure patient authorization to obtain information according to *Title 17 CCR, §2500-2505*. Fax the completed form to the Los Angeles County Vaccine Preventable Disease Control's secure FAX line at **(213) 351-2782**. Thank you for your support in assisting Public Health to more effectively contain pertussis transmission in the community.

Section 1: Patient Demographics

Name (Last Name, First Name):		
Date of Birth:	**Age:**	**Gender:** ☐ Male ☐ Female
Race: ☐ White ☐ Native American/Alaskan Native ☐ African American/Black ☐ Asian/Pacific Islander ☐ Asian-Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hawaiian ☐ Japanese ☐ Korean ☐ Laotian ☐ Samoan ☐ Vietnamese ☐ Other _____		**Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other _____
Place of Birth:	**If born outside of the US, how many years lived in US?**	
Parent Name (if less than 18):		
Address:		
Telephone Number(s):	**Home:**	**Cell:**

Section 2: Provider Information

Name of Reporting Provider:		
Name of Hospital/Practice:		
Address:		
Telephone Number(s):	**Phone:**	**Fax:**

Section 3: Hospitalization

Is the patient hospitalized?	☐ Yes ☐ No (if no, skip to Section 4)
Name of Hospital:	
Reason for admission:	
Date Admitted:	**Date Discharged:**

Section 4: Symptoms

	Yes, No, or Unknown	Date of Onset	Duration (in days)
Cough	☐ Yes ☐ No ☐ Unknown		
Paroxysms	☐ Yes ☐ No ☐ Unknown		
Whoop	☐ Yes ☐ No ☐ Unknown		
Post-tussive Vomiting	☐ Yes ☐ No ☐ Unknown		
Apnea	☐ Yes ☐ No ☐ Unknown		
Rule Out Diagnoses:			

Section 5: Immunization History

Number of DTaP dose(s):	☐ **No Pertussis Immunizations Available**
Number of Tdap dose(s):	

Section 6: Laboratory Testing *(if done)*		
	Date of Collection:	**Result:**
PCR		
Culture *(not preferred for timely diagnosis)*		
Other pertussis labs *(not preferred for lack of reliability)*		
Other positive respiratory pathogen results		

Section 7: Treatment		
Please indicate pertussis antibiotics for patient:	☐ Azithromycin ☐Other: _____	**Date Antibiotic Started:**
If no antibiotics given, please explain why.		
Were antibiotics given/recommended for family members? ☐ Yes ☐ No		

Section 8: Risk Factors		
Is suspect patient pregnant?	☐ Yes ☐ No	**If yes, number of gestational weeks.**
Is suspect patient immunocompromised?	☐ Yes ☐ No	**If yes, please explain.**
Is patient taking any immunosuppressive medications?	☐ Yes ☐ No	**If yes, please indicate.**
Is suspect patient a health care worker?	☐ Yes ☐ No	**If yes, please explain.**
Any coughing contacts (e.g. household contacts, classmates, friends, etc.)	☐ Yes ☐ No	**If yes, please list name(s) of contact(s).**
School Name *(if applicable):*		
Work Name *(if applicable):*		
If no antibiotics given, was patient told not to attend work/school? ☐ Yes ☐ No		
Any other frequently visited places/social activities:		

Comments:

Please fax completed form and all medical records for medical visit to the Los Angeles County Department of Public Health Vaccine Preventable Disease Control Program at **(213) 351-2782**.