WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Pertussis

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade:_____ Employer/School:_____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*_____ *Phone:* _____

*Birth date: __ / __ / ____ Age: _____
*Gender: ☐Male ☐Female ☐Unk

*Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

*Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

REPORTING SOURCE

*Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _____ Address: _____ _____ Phone: _____
Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____
Reporter Name: _____ _____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____
Physician Address: _____ Phone: _____

Hospital

Was patient hospitalized for this illness? ☐ **Y** ☐ **N** ☐ **U**
If yes: Hospital name: _____ Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Condition

Diagnosis date: __ / __ / ____ * Illness onset date: __ / __ / ____
Was patient <12 months old? ☐ **Y** ☐ **N** ☐ **U** If yes: Mother's age at infant birth ____ (in years) ☐ **U**
Infant birth weight ___(lbs) ___(oz) **or** ___(g) ☐ **U**

Symptoms

Y	N	U	
☐	☐	☐	Did the patient have a cough? If yes: cough onset date __/__/____
☐	☐	☐	Paroxysmal Cough
☐	☐	☐	Whoop
☐	☐	☐	Post-tussive Vomiting
☐	☐	☐	Apnea
☐	☐	☐	Did patient have a cough at final interview? Date of final interview: __/__/____ Total cough duration (in days) ____

*Complications

Result of chest x-ray for pneumonia: ☐ positive ☐ negative ☐ not done ☐ unknown

Y	N	U	
☐	☐	☐	Did the patient have generalized or focal seizures due to pertussis?
☐	☐	☐	Did the patient have acute encephalopathy due to pertussis?
☐	☐	☐	Did the patient die from pertussis or complications (including a secondary infection) associated with pertussis?

If yes Date of death: __ / __ / ____

Clinical notes

TREATMENT

Y	N	U			
☐	☐	☐	Were antibiotics given? If yes:	Antibiotic name: _____ Start date: __/__/____ Number of days actually taken: ____	Antibiotic name: _____ Start date: __/__/____ Number of days actually taken: ____

*LABORATORY *(Please submit copies of all labs to DIDE)*

Y N U

☐ ☐ ☐ Was laboratory testing done for pertussis?

☐ ☐ ☐ Were clinical specimens sent to CDC for genotyping? If yes: Date sent for genotyping: __/__/____ Specimen type: ________

☐ ☐ ☐ Culture? If yes: Culture date: __/__/____ Result: ☐ Not done ☐ Unknown ☐ Positive ☐ Negative ☐ Indeterminate ☐ Bordetella parapertussis ☐ Other bordetella spp ☐ Pending

☐ ☐ ☐ PCR? If yes: Specimen date: __/__/____ Lab where PCR performed: _________________________ Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Bordetella parapertussis ☐ Other bordetella spp ☐ Pending ☐ Unknown ☐ Not Done

*VACCINE INFORMATION

Did the patient receive a pertussis-containing vaccine? ☐ **Y** ☐ **N** ☐ **U**

If yes: Number of doses of pertussis-containing vaccine given? ___

How many doses of pertussis-containing vaccine were given 2 weeks or more before illness onset? ___

Date of last pertussis-containing vaccine given before illness: __/__/____

VACCINATION RECORD

Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ Organization Name: _____________________________________ Organization ID: _________________
Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ Organization Name: _____________________________________ Organization ID: _________________
Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ Organization Name: _____________________________________ Organization ID: _________________
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Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ Organization Name: _____________________________________ Organization ID: _________________

EPIDEMIOLOGIC

Y N U

☐ ☐ ☐ * Is this case epi-linked to a laboratory-confirmed case? If yes, case ID of epi-linked case: __________

☐ ☐ ☐ * Is this case part of a cluster or outbreak (e.g. total is 2 or more cases)? If yes, name of outbreak? _________________

☐ ☐ ☐ Were there one or more suspected sources of infection (a suspected source is another person with a cough who was in contact with the case 7-20 days before the case's cough)?

Number of suspected sources of infection: _____ (see last page for contact tracing sheet)

☐ ☐ ☐ Was there documented transmission from this case of pertussis to a new setting (outside the household)?

Transmission Setting (where did this case acquire pertussis?):

☐ Athletics	☐ College	☐ Community	☐ Correctional facility
☐ Daycare	☐ Doctor's office	☐ Home	☐ Hospital ER
☐ Hospital outpatient clinic	☐ Hospital ward	☐ International travel	☐ Military
☐ Place of worship	☐ School	☐ Work	☐ Other ☐ Unknown

PUBLIC HEALTH ACTIONS/NOTES

Earliest date of public health action: __/__/__

☐ Lost to follow up

Y N U

☐ ☐ ☐ Post exposure prophylaxis of contacts

☐ ☐ ☐ Treatment

☐ ☐ ☐ Isolation

☐ ☐ ☐ Education

*Contact Tracing Sheet									
Name/Contact Information (including guardian information for minors)	Contact or source?	Date of Birth (mm/dd/yyyy)	Sex	Relation-ship to case?	Number of doses of pertussis-containing vaccine?	Date(s) of vaccination (mm/dd/yyyy)	Is this a case? (Y/N)	Cough onset date? **(mm/dd/yyyy)**	Antibiotics received? (Y/N)

Number of contacts in any setting recommended PEP: _____

Y=Yes N=No U=Unknown

*surveillance indicator required

Division of Infectious Disease Epidemiology rev11.05.2014