

Line List for Pertussis Outbreaks

Facility Name: _____

County: _____

Contact Person Name _____

Contact Phone # _____

Demographics					Duration of Illness				Symptoms				Vaccine Information		Laboratory		Outcome		Case Status	Public Health Action	
Name	DOB	Sex	Staff or Student?	Class or room	Date of Onset	Date of cough onset	Cough duration (# of days)	Date Well	Paroxysms of Coughing (Y/N)	Inspiratory Whoop (Y/N)	Post-tussive Vomiting (Y/N)	Apnea (Y/N)	Date of Last Dose	# of Doses	Date of Lab Testing	Testing Result and Type	Hospitalized (Y/N)	Died (Y/N)	Confirmed (C), Probable (P), Not a Case (N)	Contact Tracing Completed (Y/N)	Antibiotics Received (Y/N) and # of days taken

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