

# Pertussis Case Report Investigation Form Alaska

For EPI Use Only  
 NBS ID#: \_\_\_\_\_  
 Case classification: Confirmed  
 Probable  
 Suspect

Interview date: \_\_\_\_\_

Completed by: \_\_\_\_\_

## CASE IDENTIFICATION

Name: Last, First, M.I.	Date of Birth (mm/dd/yy):	Gender: Male Female	Ethnicity (check one): Hispanic Not Hispanic Unknown	Race (check all that apply): White AI/AN Asian/PI Black Unknow
Address:	City	State	Zip code:	Phone:
Seen by a health care provider? Y N Clinic:	Occupation: School/daycare attendance: Y N			

## CLINICAL DATA

## COMPLICATIONS

## TREATMENT

Any cough? Y N Cough onset date: _____ Paroxysmal cough? Y N Whoop? Y N Post-tussive vomiting? Y N Apnea? Y N Cough at time of interview? Y N Duration of cough: _____ (# days)	Y N If Yes, describe (i.e., pneumonia, seizures, acute encephalopathy, etc.) _____ Chest X-ray for Pneumonia? Not Done Positive Negative Unknown Hospitalized? Y N If Yes, # Days: _____ Died? Y N	Antibiotics given? Y N Start date: _____ Azithromycin Dose/duration: _____ Other: _____ Dose/duration: _____
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Clinical case definition: Cough illness lasting 2 or more weeks with at least one of the following signs or symptoms: paroxysms of coughing; or inspiratory whoop; or post-tussive vomiting; or apnea (with or without cyanosis).

## LABORATORY DATA

## DTaP/Tdap VACCINATION HISTORY

## EPIDEMIOLOGIC INFORMATION

Document only medically verified vaccines.  
 Parent/guardian verbal report is not acceptable.

Was laboratory testing for pertussis done? Y N	Dose 1 antigen and date:	Close contact of a confirmed pertussis case? Y N
Laboratory Name:	Dose 2 antigen and date:	Associated with a known outbreak? Y N
Specimen date:	Dose 3 antigen and date:	Outbreak name:
PCR: Positive Negative Unknown	Dose 4 antigen and date:	Contact with children ≤ 1 year of age? Y N
Culture: Positive Negative Unknown	Dose 5 antigen and date:	3 <sup>rd</sup> trimester pregnant female in household? Y N
Serology: Positive Negative Unknown	Dose 6 antigen and date:	Setting in which pertussis was acquired?
Please provide a list of close contacts using the Pertussis Close Contact Investigation Worksheet	Reason for inadequate vaccination coverage: Religious exemption Medical exemption Unknown	Setting (outside household) of further documented spread from this case: Day Care School Doctor's Office Hospital Travel Unknown Other: _____



**Pertussis Close Contact Investigation Worksheet**

Location: \_\_\_\_\_

Completed by: \_\_\_\_\_

Index Case Name: \_\_\_\_\_

NBS ID#: \_\_\_\_\_

Date: \_\_\_\_\_

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Name:	Hospitalized? Y N	Any cough? Y N	Antibiotics given? Y N	Dose 1 date:	Transmission setting:  Home Day Care School Doctor's Office Hospital Travel Unknown Other:
DOB:	Pregnant? Y N	Cough onset date: _____	Azithromycin	Dose 2 date:	
Gender: Male Female	Immuno-compromised? Y N	Paroxysmal cough? Y N	Other: _____	Dose 3 date:	
Relation to case:	Contact w/infants? Y N	Whoop? Y N	Start date: _____	Dose 4 date:	
Address:	Attend school or childcare? Y N	Post-tussive vomiting? Y N	Chest X-Ray for Pneumonia? Not Done Unk Pos Neg	Dose 5 date:	
Comment:		Apnea? Y N		Dose 6 date:	
		Cough at time of interview? Y N		Reason for inadequate vaccination coverage: Religious exemption Medical exemption Unknown	
		Duration of cough: _____ (# days)			
		Complications (i.e., seizures, acute encephalopathy? Y N			
Name:	Hospitalized? Y N	Any cough? Y N	Antibiotics given? Y N	Dose 1 date:	Transmission setting:  Home Day Care School Doctor's Office Hospital Travel Unknown Other:
DOB:	Pregnant? Y N	Cough onset date: _____	Azithromycin	Dose 2 date:	
Gender: Male Female	Immuno-compromised? Y N	Paroxysmal cough? Y N	Other: _____	Dose 3 date:	
Relation to case:	Contact w/infants? Y N	Whoop? Y N	Start date: _____	Dose 4 date:	
Address:	Attend school or childcare? Y N	Post-tussive vomiting? Y N	Chest X-Ray for Pneumonia? Not Done Unk Pos Neg	Dose 5 date:	
Comment:		Apnea? Y N		Dose 6 date:	
		Cough at time of interview? Y N		Reason for inadequate vaccination coverage: Religious exemption Medical exemption Unknown	
		Duration of cough: _____ (# days)			
		Complications (i.e., seizures, acute encephalopathy? Y N			
Name:	Hospitalized? Y N	Any cough? Y N	Antibiotics given? Y N	Dose 1 date:	Transmission setting:  Home Day Care School Doctor's Office Hospital Travel Unknown Other:
DOB:	Pregnant? Y N	Cough onset date: _____	Azithromycin	Dose 2 date:	
Gender: Male Female	Immuno-compromised? Y N	Paroxysmal cough? Y N	Other: _____	Dose 3 date:	
Relation to case:	Contact w/infants? Y N	Whoop? Y N	Start date: _____	Dose 4 date:	
Address:	Attend school or childcare? Y N	Post-tussive vomiting? Y N	Chest X-Ray for Pneumonia? Not Done Unk Pos Neg	Dose 5 date:	
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