



Pertussis

County _____

Case name (last, first) _____
 Birth date ___/___/___ Age at symptom onset _____ Years Months
 Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply)

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (*specify*: Amer Ind *and/or* AK Native) Asian Black or African American
 Native HI/Pacific Islander (*specify*: Native HI *and/or* Pacific Islander) White Patient declined to respond Unk

Additional race information:

Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
 Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
 Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
 Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
 Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
 Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
 Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
 South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
 Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
 Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
 Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
 Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
 Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
 Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____
 Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk

Clinical Features

Y N Unk

Cough Onset date ___/___/___
 Coughing at final interview Date of final interview ___/___/___ Cough duration at final interview _____ days
 Cough lasting at least two weeks
 Post-tussive vomiting
 Paroxysms of coughing Onset date ___/___/___
 Inspiratory whoop
 Apnea (with or without cyanosis)
 Cyanosis
 Seizure new with disease
 Pneumonia
 Diagnosed by X-Ray CT MRI Provider Only
 Result Positive Negative Indeterminate Not tested Other _____
 Acute encephalopathy
 White blood cell total _____ Date ___/___/___ Highest WBC result (% of lymphocytes) _____

Vaccination

Y N Unk

Ever received pertussis containing vaccine Number of pertussis doses prior to illness _____

Vaccine information available Yes No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

Vaccine lot number _____ Administering provider _____

Information source Washington Immunization Information System (WIIS) WIIS ID number _____

Medical record Patient vaccination card Verbal only/no documentation Other state IIS

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Y N Unk

Pertussis vaccination up to date for age per ACIP

Vaccine series not up to date reason

Religious exemption Medical contraindication Philosophical exemption

Laboratory confirmation of previous disease MD diagnosis of previous disease

Underage for vaccine Parental refusal Other Unknown

For infant cases (<1 year old)

Y N Unk

Did mother receive TDAP during this pregnancy

If yes, Trimester Tdap received First Second Third Date received ___/___/___

If no, Reason for no vaccination during pregnancy Not offered Declined Had previous dose Ukn

Other _____

Dates mother received TDAP prior to pregnancy ___/___/___

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*

Autopsy performed

Death certificate lists disease as a cause of death or a significant contributing condition

Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)

Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures 5-21 days before symptom onset)

Risk and Exposure Information

Y N Unk

- Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
- Contact with recent foreign arrival Country _____ Date(s) of contact ___/___/___
- Does the case know anyone else with similar symptoms or illness
Onset date, shared meals, relationship, etc. _____
- Congregate living
 - Barracks Corrections Long term care Dormitory Boarding school Camp Shelter
 - Other _____

Exposure and Transmission Summary

Y N Unk

- Epidemiologically linked to a lab positive case classified as confirmed**
- Epidemiologically linked to a lab positive infant case classified as probable**
- Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk
- International travel related During entire exposure period During part of exposure period No international travel
- Suspected exposure type Person to person Health care associated Unk Other _____
Describe _____
- Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____
Describe _____
- Exposure summary _____

- Suspected transmission type (check all that apply) Person to person Health care associated Unk
 Other _____
Describe _____
- Suspected transmission setting (check all that apply) Day care/Childcare School (not college) Doctor's office
 Hospital ward Hospital ER Hospital outpatient facility Home Work College Military
 Correctional facility Place of worship Laboratory Long term care facility Homeless/shelter
 International travel Out of state travel Transit Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____
Describe _____

Public Health Issues

Y N Unk

- Contact with high-risk persons or sensitive occupations/settings
Circumstances (select all that apply)
 - Attends childcare or preschool
 - Employed in childcare or preschool
 - Work or volunteer in health care setting
 - Face to face contact with infant <12 months of age
 - Face to face contact with pregnant woman
 - Household member or close contact in sensitive occupation or setting (HCW, childcare)
 - Contact with other high-risk persons/settings _____
- Evaluate immune status of close contacts Yes Date initiated ___/___/___
Number of close contacts evaluated for immune status _____
Number of susceptible contacts identified _____
 - No, close contacts not evaluated
 - No, case had no close contacts
 - Unk
- Number of physician visits since onset of this illness _____
- Number of residents in primary household _____

If needed, enter detailed information in the Transmission Tracking Question Package

LAB RESULTSLab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest result status Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date ___/___/___

Upload documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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