



Texas Department of State
Health Services

Infectious Disease Control Unit, Texas Department of State Health Services

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Pertussis Case Track Record

FINAL STATUS:

- ☐ CONFIRMED
☐ PROBABLE
☐ RULED OUT /NOT A CASE

NBS PATIENT ID#:

NBS INVESTIGATION ID#:

Patient's Name: _____
last first

Address: _____

City: _____ County: _____ Zip: _____

Region: _____ Phone: () _____

Parent/Guardian: _____

Physician: _____ Phone: () _____

Address: _____

☐ Check box if history of homelessness in last 6 months

Reported by: _____

Agency: _____

Phone: () _____

Date reported: ____/____/____

Investigated by: _____

Agency: _____

Phone: () _____

Email: _____

Investigation start date: ____/____/____

Date investigation completed: ____/____/____

DEMOGRAPHICS: DATE OF BIRTH: ____/____/____ AGE: _____ PLACE OF BIRTH: ☐ USA ☐ Other: _____ ☐ Unknown

SEX: ☐ Male ☐ Female ☐ Unknown

RACE: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pac. Islander ☐ Am. Indian or Alaska Native ☐ Unknown ☐ Other: _____

HISPANIC: ☐ Yes ☐ No ☐ Unknown

Was the patient <12 months old? ☐ Yes ☐ No If yes, Mother's age at date of infant birth: _____

Infant birth weight: _____ lbs _____ oz OR _____ g OR ☐ Unknown

If female, is patient currently pregnant? ☐ Yes ☐ No ☐ Unknown

Obstetrician's name, address, and phone #: _____

If yes, estimated date and location of delivery: ____/____/____

CLINICAL DATA:

Symptom onset date: ____/____/____

Diagnosis date: ____/____/____

Illness end date: ____/____/____

Final Cough Duration (total # of days): _____ Days

Symptoms:

Paroxysmal Cough

☐ Yes / ☐ No

Inspiratory Whoop

☐ Yes / ☐ No

Post-tussive Vomiting

☐ Yes / ☐ No

Apnea (exclude cyanotic episode) (under 1 yr old only)

☐ Yes / ☐ No

Is the patient still coughing at final interview?..... ☐ Yes / ☐ No

Date of final interview: ____/____/____

Additional Symptoms:

Acute Encephalopathy

☐ Yes / ☐ No

Cyanosis after Paroxysm

☐ Yes / ☐ No

Seizures (Focal or Generalized)

☐ Yes / ☐ No

Pneumonia Chest X-Ray

☐ Yes / ☐ No

Other _____

☐ Yes / ☐ No

Does patient have history of Asthma/Bronchitis?..... ☐ Yes / ☐ No

TREATMENT:

Were antibiotics given? ☐ Yes / ☐ No

☐ Azithromycin: Date Started: ____/____/____ for _____ Days

☐ Bactrim: Date Started: ____/____/____ for _____ Days

☐ Clarithromycin: Date Started: ____/____/____ for _____ Days

☐ Erythromycin: Date Started: ____/____/____ for _____ Days

☐ Other: _____ Date Started: ____/____/____ for _____ Days

☐ Other: _____ Date Started: ____/____/____ for _____ Days

Was the patient hospitalized for this illness? ☐ Yes / ☐ No

Hospitalized at: _____

Admitted: ____/____/____ Discharged: ____/____/____

Duration of Stay: _____ days

Did patient die? ☐ Yes*, died on: ____/____/____

☐ No

☐ Unknown

**If patient is <1 yr old, please fill out and fax the Pertussis Death Worksheet to 512-776-7616.*

LABORATORY DATA: Was laboratory testing done? ☐ Yes ☐ No ☐ UnknownLABORATORY: ☐ DSHS ☐ Other: _____

Ordering Provider: _____ Reporting Facility: _____

☐ PCR: Date specimen collected: ____/____/____ Result: _____ Lab Report Date: ____/____/____

☐ Culture: Date specimen collected: ____/____/____ Result: _____ Lab Report Date: ____/____/____

☐ Other: Date specimen collected: ____/____/____ Result: _____ Lab Report Date: ____/____/____

VACCINATION HISTORY: CDC Objective: 90% of pertussis cases must have a vaccination history captured.VACCINATED: ☐ Yes ☐ No ☐ Unknown Number of doses received: _____1st Dose: ____/____/____ Type: _____ Manufacturer: _____ Lot #: _____2nd Dose: ____/____/____ Type: _____ Manufacturer: _____ Lot #: _____3rd Dose: ____/____/____ Type: _____ Manufacturer: _____ Lot #: _____4th Dose: ____/____/____ Type: _____ Manufacturer: _____ Lot #: _____5th Dose: ____/____/____ Type: _____ Manufacturer: _____ Lot #: _____6th Dose: ____/____/____ Type: _____ Manufacturer: _____ Lot #: _____

Use the following for vaccine type:

DTaP, DTP, Tdap, Pediarix (DTaP/IPV/Hep B), Pentacel (DTaP/IPV/Hib), or Kinrix (DTaP/IPV)

If not vaccinated or has <3 doses, indicate reason:

☐ Religious Exemption ☐ Medical Contraindication ☐ Under Age ☐ Parental Refusal ☐ Unknown ☐ Other: _____

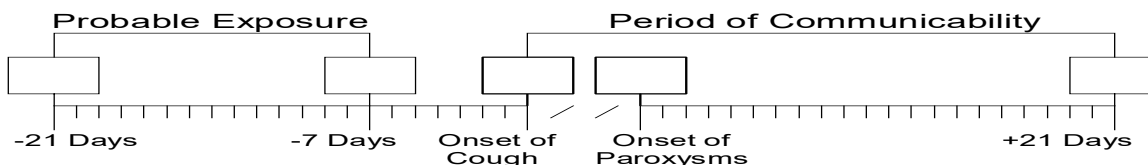
If vaccinated, please indicate:

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

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

For cases <1 year of age, was the mother given Tdap? ☐ Yes / ☐ No Date Received: ____/____/____If yes, when? ☐ At Delivery ☐ Postpartum ☐ During Pregnancy ☐ UnknownIf date is unknown, ☐ 2nd Trimester ☐ 3rd Trimester ☐ Vaccinated at Delivery ☐ Vaccinated after delivery >1 day**INFECTION TIMELINE:**

Enter onset of cough. Count backwards and forwards to enter dates for probable exposure and communicable periods.

**SOURCE OF INFECTION:** ☐ No exposure identified ☐ Close contact with a known or suspected case: NBS Pt ID: _____Where did this case acquire pertussis? ☐ Day-care ☐ School ☐ College ☐ Work ☐ Home ☐ Dr. Office ☐ Hospital ER☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Military ☐ Jail ☐ Church ☐ Travel ☐ Unknown ☐ Other: _____Has any travel occurred within the exposure period? ☐ Yes ☐ No ☐ Unknown If yes, list location: _____Is case part of an outbreak? ☐ Yes ☐ No ☐ Unknown If yes, list outbreak name: _____**TRANSMISSION LOCATIONS:**Did the case-patient attend school/daycare? ☐ Yes / ☐ No

If yes, which school/daycare? _____ Grade: _____ Teacher: _____

Last date of attendance: ____/____/____ Date Returned: ____/____/____

Transportation to school: ☐ Walk ☐ Carpool ☐ Car ☐ Bus# _____ ☐ Other _____

After school care: _____ Other after school activities: _____

Did the case-patient attend any of the following while symptomatic? ☐ Sleepover ☐ Church Activities ☐ Babysit ☐ Visit Hospital Patient

HOUSEHOLD CONTACTS: Were control activities initiated?: ☐ Yes ☐ No ☐ Unknown If no, explain: _____

Name	Relation to Case	Age	Vaccination HX	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Number of contacts recommended to receive antibiotics prophylaxis: _____

Antibiotic prophylaxis is recommended for household and high-risk contacts (infants, contacts of infants, immunocompromised)

***Investigations should be completed on all symptomatic contacts of confirmed or probable cases**

ADDITIONAL CONTACTS:

Setting: ☐ No Spread ☐ Day-care ☐ School ☐ College ☐ Work ☐ Home ☐ Dr. Office ☐ Hospital ER ☐ Hospital Inpatient
☐ Hospital Outpatient ☐ Military ☐ Jail ☐ Church ☐ Travel ☐ Unknown ☐ Other: _____

Name (s) of Settings: _____

Name	Relation to Case	Age	Vaccination HX	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

***Investigations should be completed on all contacts with symptoms**

COMMENTS: