



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Infectious Disease Control Unit, Texas Department of State Health Services

P.O. Box 149347, MC 1960

Austin, Texas 78714

Phone: (512) 776-7676 Fax: (512) 776-7616

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.*