TEXAS Health and Human Services | 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: patient_name
last first

Address: address

City: city County: county Zip: zip

Region: region Phone: ( )

Parent/Guardian: parent

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

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

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

_____

**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.*

Patient History – Pertussis Pt. Name: patient_name NBS Pt. ID:_____

**LABORATORY DATA:** Was laboratory testing done? ☐ Yes ☐ No ☐ Unknown

*LABORATORY:* ☐ 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: _____/_____/_____

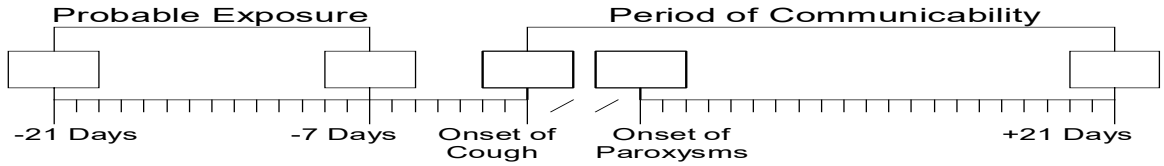
**For cases <1 year of age, was the mother given Tdap?** ☐Yes / ☐No **Date Received: _____/_____/_____**

If yes, when? ☐ At Delivery ☐ Postpartum ☐ During Pregnancy ☐ Unknown

If 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

Patient History – Pertussis Pt. Name: patient_name NBS Pt. ID: _____

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

**COMMENTS:**