TEXAS Health and Human Services | 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

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.*