



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.*