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#: patient_nbs_id

NBS INVESTIGATION ID#: patient_investigation_id

Patient's Name: patient's_last_name (last) patients_first_name (first)
Address: patients_address
City: patients_city County: patients_country Zip: patients_zip
Region: patient_r Phone: ( )
Parent/Guardian: patient_parent
Physician: patient_doctor Phone: ( )
Address: patient_address_box1
patient_address_box2
☐ Check box if history of homelessness in last 6 months

Reported by: patient_reported_by
Agency: patient_agency
Phone: ( )
Date reported: 00 / 00 / 0000
Investigated by: patient_investigated_by
Agency: patient_agency
Phone: ( )
Email: patient_email
Investigation start date: 00 / 00 / 00
Date investigation completed: 00 / 00 / 00

DEMOGRAPHICS: *DATE OF BIRTH:* 10 / 11 / 1989 *AGE:* 29 *PLACE OF BIRTH:* ☐ USA ☒ Other: Canada ☐ Unknown

SEX: ■ Male ☐ Female ☐ Unknown

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

HISPANIC: ☐ Yes ■ No ☐ Unknown

Was the patient <12 months old? ☐ Yes ■ No If yes, Mother's age at date of infant birth: 10/00/000

Infant birth weight: 5 lbs 4 oz OR 24 g OR ☐ Unknown

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

If yes, estimated date and location of delivery: 11 / 11 / 1111

Obstetrician's name, address, and phone #: obsetriican_name_1
obsterician_name_2

CLINICAL DATA:

Symptom onset date: ____/____/____
Diagnosis date: ____/____/____
Illness end date: ____/____/____
Final Cough Duration (total # of days): 10 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 other_symptoms	☐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: patient_hospital_location
Admitted: ____/____/____ Discharged: ____/____/____
Duration of Stay: 10 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.*