Washington State Department of Health

Pertussis

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____

LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification ☐ Classification pending ☐ Confirmed
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status
☐ In progress
☐ Complete
☐ Complete – not reportable to DOH
☐ Unable to complete Reason _____

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

Employed ☐ Yes ☐ No ☐ Unk Occupation _____
Industry _____ Employer _____
Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk
Type of school ☐ Preschool/day care ☐ K-12 ☐ College
☐ Graduate School ☐ Vocational ☐ Online ☐ Other
School name _____
School address _____
City/State/County _____ Zip _____
Phone number _____ Teacher's name _____

REPORT SOURCE

Initial report source _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

COMMUNICATIONS

Primary HCP name _____
Phone _____

OK to talk to patient (If Later, provide date)
☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___
☐ Complete ☐ Partial ☐ Unable to reach

☐ Patient could not be interviewed

Alternate contact ☐ Parent/Guardian ☐ Spouse/Partner
☐ Friend ☐ Other _____
Name _____ Phone _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived Diagnosis date ___/___/___
Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Clinical Features

Y	N	Unk	
☐	☐	☐	**Cough** Onset date ___/___/___
☐	☐	☐	Coughing at final interview Date of final interview ___/___/___ Cough duration at final interview _____ days
☐	☐	☐	**Cough lasting at least two weeks**
☐	☐	☐	**Post-tussive vomiting**
☐	☐	☐	**Paroxysms of coughing** Onset date ___/___/___
☐	☐	☐	**Inspiratory whoop**
☐	☐	☐	**Apnea (with or without cyanosis)**
☐	☐	☐	Cyanosis
☐	☐	☐	Seizure new with disease
☐	☐	☐	Pneumonia

Diagnosed by ☐ X-Ray ☐ CT ☐ MRI ☐ Provider Only
Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Not tested ☐ Other _____

☐ ☐ ☐ Acute encephalopathy
White blood cell total _____ Date ___/___/___ Highest WBC result (% of lymphocytes) _____

Pertussis required variables are in **bold.** Answers are: Yes, No, Unknown to case

Case Name ________________________________ LHJ Case ID ________________________________

Vaccination

Y N Unk

☐ ☐ ☐ **Ever received pertussis containing vaccine** Number of pertussis doses prior to illness _______

Vaccine information available ☐ Yes ☐ No

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ___/___/___ Vaccine administered (Type) ________________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Date of vaccine administration ______________________ Vaccine administered (Type) ________________________
Vaccine lot number ______________________________ Administering provider ______________________________
Information source ☐ Washington Immunization Information System (WIIS) WIIS ID number ______________________
☐ Medical record ☐ Patient vaccination card ☐ Verbal only/no documentation ☐ Other state IIS

Y N Unk

☐ ☐ ☐ Pertussis vaccination up to date for age per ACIP

Vaccine series not up to date reason
☐ Religious exemption ☐ Medical contraindication ☐ Philosophical exemption
☐ Laboratory confirmation of previous disease ☐ MD diagnosis of previous disease
☐ Underage for vaccine ☐ Parental refusal ☐ Other ☐ Unknown

For infant cases (<1 year old)

Y N Unk

☐ ☐ ☐ Did mother receive TDAP during this pregnancy

If yes, Trimester Tdap received ☐ First ☐ Second ☐ Third Date received ___/___/___

If no, Reason for no vaccination during pregnancy ☐ Not offered ☐ Declined ☐ Had previous dose ☐ Ukn
☐ Other ____

Dates mother received TDAP prior to pregnancy ___/___/___

Hospitalization

Y N Unk

☐ ☐ ☐ **Hospitalized at least overnight for this illness** Facility name ______________________________

Hospital admission date ___/___/___ Discharge ___/___/___ HRN ____________________

☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk

☐ ☐ ☐ **Died of this illness** Death date ___/___/___ *Please fill in the death date information on the Person Screen*

☐ ☐ ☐ Autopsy performed

☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition

Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital) ☐ Emergency department (ED)
☐ Inpatient ward ☐ ICU ☐ Other ______________________________

Case Name _____ LHJ Case ID _____

RISK AND RESPONSE (Ask about exposures 5-21 days before symptom onset)

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____

☐ ☐ ☐ Contact with recent foreign arrival Country _____ Date(s) of contact ___/___/___

☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness
Onset date, shared meals, relationship, etc. _____

☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care ☐ Dormitory ☐ Boarding school ☐ Camp ☐ Shelter
☐ Other _____

Exposure and Transmission Summary

Y N Unk

☐ ☐ ☐ **Epidemiologically linked to a lab positive case classified as confirmed**

☐ ☐ ☐ **Epidemiologically linked to a lab positive infant case classified as probable**

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____
☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Person to person ☐ Health care associated ☐ Unk ☐ Other _____
Describe _____

Suspected exposure setting ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military ☐ Correctional facility ☐ Place of worship
☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter ☐ International travel ☐ Out of state travel ☐ Transit
☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Exposure summary

Suspected transmission type (check all that apply) ☐ Person to person ☐ Health care associated ☐ Unk
☐ Other _____
Describe _____

Suspected transmission setting (check all that apply) ☐ Day care/Childcare ☐ School (not college) ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home ☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Place of worship ☐ Laboratory ☐ Long term care facility ☐ Homeless/shelter
☐ International travel ☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant
☐ Hotel/motel/hostel ☐ Other _____
Describe _____

Public Health Issues

Y N Unk

☐ ☐ ☐ Contact with high-risk persons or sensitive occupations/settings
Circumstances (select all that apply)
☐ Attends childcare or preschool
☐ Employed in childcare or preschool
☐ Work or volunteer in health care setting
☐ Face to face contact with infant <12 months of age
☐ Face to face contact with pregnant woman
☐ Household member or close contact in sensitive occupation or setting (HCW, childcare)
☐ Contact with other high-risk persons/settings _____

Evaluate immune status of close contacts ☐ Yes Date initiated ___/___/___
Number of close contacts evaluated for immune status _____
Number of susceptible contacts identified _____
☐ No, close contacts not evaluated
☐ No, case had no close contacts
☐ Unk

Number of physician visits since onset of this illness _____

Number of residents in primary household _____

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk

☐ ☐ ☐ Prophylaxis of appropriate contacts recommended Date initiated ___/___/___
Number of contacts recommended prophylaxis _____
Number of contacts receiving prophylaxis _____
Number of contacts completing prophylaxis _____

☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___

☐ ☐ ☐ Any other public health action _____

TRANSMISSION TRACKING

Contagious period: At symptom onset, at least 21 days or until after 5 days antibiotic

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk

Settings and details (check all that apply)

☐ Day care ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Health care ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

☐ ☐ ☐ Did patient receive prophylaxis/treatment
Specify medication _____ ☐ Antibiotic ☐ Fungal/Parasitic ☐ Antiviral ☐ Immune globulin/Antitoxin
☐ Other _____
Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribed dose _____ ☐ g ☐ mg ☐ ml Frequency _____ Duration _____ ☐ Days ☐ Weeks ☐ Months
Indication ☐ PEP ☐ Treatment for disease ☐ Incidental ☐ Other _____
Did patient take medication as prescribed ☐ Yes ☐ No - Why not _____ ☐ Unk
Prescribing provider _____

NOTES

LAB RESULTS

Lab report information
Lab report reviewed – LHJ ☐
WDRS user-entered lab report note

Submitter _____
Performing lab for entire report _____
Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date ___/___/___ Specimen received date ___/___/___
WDRS specimen type _____
WDRS specimen source site _____
WDRS specimen reject reason _____

Test performed and result
WDRS test performed _____
WDRS test result, coded _____
WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____
WDRS unit of measure _____
Test method _____
WDRS interpretation code _____
Test result – Other, specify _____
WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
Upload document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____