



Pertussis

County _____

Case name (last, first) _____
 Birth date ___/___/___ Age at symptom onset _____ Years Months
 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 Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

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

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply)

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American
 Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:

- Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
- Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
- Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
- Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
- Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
- Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
- Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
- South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
- Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

- Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
- Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
- Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
- Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
- Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
- Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

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 _____

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

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) _____

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) _____

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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 _____

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)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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 RESULTSLab 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 PendingTest 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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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