



Pertussis Case Report Form

Phone.....360-778-6100

Fax360-778-6103

Report Line.....360-778-6150

DEMOGRAPHICS

All cases including suspected are notifiable within 24 hours

NAME: Last _____ First _____ MI _____
D.O. B: ___/___/___ Sex: M F Best Contact Phone: _____
Patient's Guardian or Parent (if minor) _____

SYMPTOMS (Symptoms in **bold** suspicious for pertussis)

	<u>Yes</u>	<u>No</u>	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Onset date: ___/___/___
Whoop	<input type="checkbox"/>	<input type="checkbox"/>	Onset date: ___/___/___
Paroxysms (coughing in fits, bursts)	<input type="checkbox"/>	<input type="checkbox"/>	Onset date: ___/___/___
Post-tussive vomiting (after coughing)	<input type="checkbox"/>	<input type="checkbox"/>	Onset date: ___/___/___
Apnea (infants <1 year old)	<input type="checkbox"/>	<input type="checkbox"/>	

SOCIAL & RISK FACTORS

	<u>Yes</u>	<u>No</u>	
Exposure to a pertussis case in past 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	Date and Place of Exposure:
Patient < 1 year old?*	<input type="checkbox"/>	<input type="checkbox"/>	
Attends childcare or school?*	<input type="checkbox"/>	<input type="checkbox"/>	
Close contact with a high-risk person(s)?*			
Pregnant women	<input type="checkbox"/>	<input type="checkbox"/>	
Infant(s) < 1 year old	<input type="checkbox"/>	<input type="checkbox"/>	
Anyone who may expose infants <1 year of age or pregnant women (childcare workers, HCPs)	<input type="checkbox"/>	<input type="checkbox"/>	

CONSIDER TESTING

	<u>Yes</u>	<u>No</u>	
Specimen sent to commercial lab?	<input type="checkbox"/>	<input type="checkbox"/>	Date specimen obtained: ___/___/___

***Note:** Pertussis testing should done for symptomatic persons who are either high-risk or who may expose someone who is high-risk. Testing is appropriate up until 3 weeks after onset of paroxysmal cough. Contact WCHD to talk about testing at the Public Health Lab for high-risk patients whom you think should be tested but who are uninsured. **A negative test does not rule out pertussis.**

PATIENT TREATMENT/PROPHYLAXIS

	<u>Yes</u>	<u>No</u>	
Antibiotic prescribed at time of visit?	<input type="checkbox"/>	<input type="checkbox"/>	Name of Antibiotic: _____
Prophylaxis prescribed to household contacts?	<input type="checkbox"/>	<input type="checkbox"/>	Number of contacts: _____

Note: Treat whether or not you test and regardless of vaccination status if pertussis is highly suspected. Do not wait for test results. Treat within 21 days of paroxysmal cough onset. Exclude patient from all public contact until 5 days antibiotic has been completed. Arrange prophylaxis (preventive antibiotics) for household and close contacts.

PATIENT EXCLUSION

Patient excluded from daycare, school, work, or other settings with young infants or pregnant women until 5 days of antibiotic therapy or for 21 days after paroxysmal cough onset if not treated.
Yes No

NAME OF PROVIDER: _____ PHONE: _____
DATE OF VISIT: ___/___/___ DATE REPORTED: ___/___/___