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Arizona Department of Health Services

Send or Fax to:
ADHS Infectious Disease Epidemiology
150 North 18th Ave, Suite 140
Phoenix, Arizona 85007-3237
(602) 364-3199 Fax

ADHS Use Only:

PERTUSSIS

MEDSIS Case No: _____

County: _____

☐Suspected ☐LTFU ☐Confirmed
☐Ruled Out ☐Probable

REPORT SOURCE

Initial Report Date: _____

Reporter Name:_____

Reporter Org.: _____

Reporter Phone: _____

Provider Name:_____

Provider Org.: _____

Provider Phone: _____

PATIENT INFORMATION

NAME (Last, First) _____

Street Address _____

City _____ State _____ Zip _____

Mailing Address _____

Phone _____ Alt. Phone _____

Occupation/School Grade:_____

Employer/School/Other: _____

Alt. Contact _____ Phone _____

☐Parent/Guardian ☐Spouse ☐Other _____

Birthdate ____ / ____ / ____ or Age _____ Sex: ☐Male ☐Female ☐Unknown/Other

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Race: ☐White ☐African American ☐Native Hawaiian/Pacific Islander
☐ Asian ☐ Am Indian/AK Native ☐ Other _____

CLINICAL

Onset Date: ____ / ____/ ____ ☐Unknown Diagnosis Date: ____ / ____ / _____ Illness Duration: _____ days ☐Ongoing

Signs and Symptoms

Y	N	UN	
☐	☐	☐	Cough onset: ____ / ____/ ____
☐	☐	☐	Cough at final interview ____ / ____/ ____ Duration: _____ days at final interview
☐	☐	☐	Cough lasted at least 14 days?
☐	☐	☐	Paroxysms
☐	☐	☐	Whoop
☐	☐	☐	Posttussive vomiting
☐	☐	☐	Apnea
☐	☐	☐	Cyanosis

Complications

☐	☐	☐	Pneumonia
☐	☐	☐	Seizures due to pertussis
☐	☐	☐	Acute encephalopathy

Other Symptoms: _____

Hospitalization

Y	N	UN		
☐	☐	☐	Hospitalized	☐ED Only

Hospital: _____

Admit Date ___ / ___ / ____ Discharge Date____ / ____/ ____

☐ ☐ ☐ Died Death Date ____ / ____/ ____

☐ ☐ ☐ Autopsy Death Cert # _____

Laboratory Results

P	N	UN		Date collected
☐	☐	☐	Culture	____ / ____/ ____
☐	☐	☐	DFA	___ / ___ / ____
☐	☐	☐	PCR	___ / ___ / ____
☐	☐	☐	CXR for pneumonia	___ / ___ / ____
☐	☐	☐	Other	___ / ___ / ____

Serology Results

P	N	UN		
☐	☐	☐	IgM Antibodies	Titre: _____
☐	☐	☐	IgA Antibodies	Titre: _____
☐	☐	☐	IgG Antibodies	Titre: _____

Date collected: ____ / ____/ ____

Y= Yes N=No UN=Unknown P=Positive N=Negative

PERTUSSIS Name (Last, First) _____

VACCINATION HISTORY

Y N UN
☐ ☐ ☐ Case received pertussis containing vaccine?

Number of doses received prior to illness onset _____

Vx date	Vx Type	Vx Manufacturer	Vx Lot Number
___/___/____	_____	_____	_____
___/___/____	_____	_____	_____
___/___/____	_____	_____	_____
___/___/____	_____	_____	_____
___/___/____	_____	_____	_____

Vaccine Type Codes

W-DTP Whole Cell	T-DTP/Hib	N-DTaP/IPV/Hib
A-DTaP	P-Pertussis only	K-DTaP/IPV
H-DTaP/Hib	X-Tdap	O- Other
D-DT or Td	V-DTaP/IPV/HBV	U-Unknown

Vaccine Manufacturer Codes

C-sanofi pasteur	I-Mich. Health Dept
L-Wyeth	N-North American Vaccine
S-GlaxoSmithKline	O-Other
M-Mass. Health Dept.	

If case has received < 3 doses of pertussis –containing vaccine, reason?

☐Religious Exemption (1)
☐Medical Contraindication (2)
☐Philosophical Exemption (3)
☐Prev. pertussis by Lab or MD (4)
☐Parental Refusal (5)
☐Age < 7 months (6)
☐Other (7)
☐Unknown (8)

EXPOSURE

Cough onset date: ____ / ____/ ____ ☐Estimated

Likely exposure period: Onset-18 days: ____ / ____/ ____ Onset-7 days: ____ / ____/ ____

Likely infectious period: Onset-2 days: ____ / ____/ ____ Treatment start+5 or Onset+21 days: ____ / ____/ ____

Acquisition Setting
(in what setting did patient most likely acquire pertussis?)

1-Daycare	6-Hosp Outpt. Clinic	11-Military
2-School	7-Home	12-Correctional fac.
3-Doctor's Office	8-Work	13-Church
4-Hospital Ward	9-Unknown	14-Int. Travel
5-Hospital ER	10-College	15-Other

Transmission Setting
(in what setting did patient most likely transmit pertussis to others?)

1-Daycare	6-Hosp Outpt. Clinic	11-Military
2-School	7-Home	12-Correctional fac.
3-Doctor's Office	8-Work	13-Church
4-Hospital Ward	9-Unknown	14-Int. Travel
5-Hospital ER	10-College	15-Other

TREATMENT

Were antibiotics given? **Y** ☐ **N** ☐ **UN** ☐

1st antibiotic received _____ **Date started** ___/___/____
2nd antibiotic received _____ **Date started** ___/___/____

1-Erythromycin (Pediazole, Ilosone)
2-Cotrimoxazole (TMP-SMX)
3-Clarithromycin/Azithromycin (Biaxin, Z-Pak)
4-Tetracycline/Doxycycline
5-Amoxicillin/Penicillin/Ampicillin/Augmentin/Ceclor/Cefotaxime
6 Other _____

Treatment information notes:
_____
_____
_____
_____

Y= Yes N=No UN=Unknown P=Positive N=Negative

PUBLIC HEALTH

☐Education on illness provided
☐Case isolated during infectious period
☐Droplet precautions if hospitalized
☐H/H & close contacts identified and notified, employer notified if appropriate
☐H/H & close contacts appropriately prophylaxed
☐School/childcare/group notification if appropriate & exclusion of unvaccinated contacts
☐Case contact with infants or pregnant women
☐Case/contacts symptomatic before/after case?
☐Immune status of H/H and close contacts assessed
☐H/H contact works/attends childcare or healthcare facility
☐Healthcare facility exposure evaluated, facility advised on notification of clients
☐Patient could not be interviewed
☐No risk factors/exposures could be identified

Y	N	UN	
☐	☐	☐	Epi linked to a confirmed case

Case ID_____

Case Name_____

Y	N	UN	
☐	☐	☐	Epi linked to a clinically compatible case

Case ID_____

Case Name _____

☐ Outbreak related

Name: _____

NOTES

INVESTIGATOR(S): _____ DATE:____ / ____/ ____ DATE CLOSED: ____ / ____/ ____

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PERTUSSIS Name (Last, First) _____

Record activities where the case may have been exposed to pertussis and where the case may have exposed others

EXPOSURE PERIOD

Day –21
Day –20
Day –19
Day –18
Day –17
Day –16
Day –15
Day –14
Day –13
Day –12
Day –11
Day –10
Day –9
Day –8
Day –7
Day –6
Day –5
Day –4
Day –3
Day –2
Day –1

INFECTIOUS PERIOD (UNTREATED)

Day 0 (cough onset)
Day 1
Day 2
Day 3
Day 4
Day 5
Day 6
Day 7
Day 8
Day 9
Day 10
Day 11
Day 12
Day 13
Day 14
Day 15
Day 16
Day 17
Day 18
Day 19
Day 20
Day 21

(if treated, to the fifth day after start of treatment)