Pertussis

Agency:

Investigator: **Phone number:**

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: _____ Date of Birth: ___/___/___ Estimated? ☐ Age: _____

First and middle name: _____ Gender: ☐ Female ☐ Male ☐ Other _____

Maiden name: _____ Suffix: _____ Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: ___/___/___

Address line: _____ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed

Zip: _____ City: _____ Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian

State: _____ County: _____

Phone: (___)___-____ Type: _____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Long-term care resident: ☐ Yes ☐ No ☐ Unknown Parent/Guardian name: _____

Facility name: _____ Parent/Guardian phone: (___)___-____ Type: _____

EVENT

Diagnosis date: ___/___/___ Onset date: ___/___/___

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name: _____

Exposure setting: _____

Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: _____

Location acquired:
☐ In USA, in reporting state
☐ In USA, outside reporting state
☐ Outside USA
☐ Unknown

State: _____ Country: _____

Healthcare provider information

Last name: _____

First name: _____

Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____ City: _____

State: _____ County: _____

Phone : (___)___-____ Type: _____

LABORATORY FINDINGS

Laboratory: _____ Accession #: _____ Collection date: ___/___/___

Date received: ___/___/___ Specimen source: _____ Test type: ☐ Culture ☐ PCR

Result type: ☐ Preliminary ☐ Final Result date: ___/___/___ Result: ☐ Negative ☐ No growth ☐ Positive ☐ Indeterminate ☐ Equivocal

Organism:

Laboratory: _____ Accession #: _____ Collection date: ___/___/___

Date received: ___/___/___ Specimen source: _____ Test type: ☐ Culture ☐ PCR

Result type: ☐ Preliminary ☐ Final Result date: ___/___/___ Result: ☐ Negative ☐ No growth ☐ Positive ☐ Indeterminate ☐ Equivocal

Organism:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Note: The cough duration, cough type, and symptoms must be documented for IDPH to status case.

Symptoms

Cough: ☐ Yes ☐ No ☐ Unk Cough type: ☐ Paroxysmal ☐ Whoop ☐ Other Onset Date: / /

Symptoms: ☐ Apnea event ☐ Pneumonia ☐ Post-tussive vomiting ☐ Seizures ☐ None listed above

Chest X-ray done: ☐ Yes ☐ No ☐ Unk X-ray result: _____

X-ray date / /

Encephalopathy ☐ Yes ☐ No ☐ Unk

Pneumonia: ☐ Yes ☐ No ☐ Unk Final interview date: / / Cough at final interview: ☐ Yes ☐ No ☐ Unk Duration in days: _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.

EXPOSURE PERIOD — **Onset** — **COMMUNICABLE PERIOD**

Average incubation period for **pertussis** is 9-10 days with a range of 6-20 days.

Pertussis is communicable for 21 days after the start of symptoms or five days after the start of antibiotics.

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:		Antibiotic:	Antibiotic:
Date started:	/ /	Date started: / /	Date started: / /
Dose:		Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU	# of days:	Unit: ☐ mg ☐ ml ☐ IU	# of days: Unit: ☐ mg ☐ ml ☐ IU # of days:
# of times a day:	Route:	# of times a day: Route:	# of times a day: Route:

RISK FACTORS/TRAVEL

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk — City in Iowa: _____ — Departure date: / / — Return date: / /

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk — State: _____ City: _____ — Departure date: / / — Return date: / /

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk — Country: _____ — Departure date: / / — Return date: / /

Setting Acquired

Child care ☐ Yes ☐ No ☐ Unk	Home ☐ Yes ☐ No ☐ Unk	Military ☐ Yes ☐ No ☐ Unk
Church ☐ Yes ☐ No ☐ Unk	Hospital ward ☐ Yes ☐ No ☐ Unk	School ☐ Yes ☐ No ☐ Unk
College ☐ Yes ☐ No ☐ Unk	Hospital outpatient ☐ Yes ☐ No ☐ Unk	Work ☐ Yes ☐ No ☐ Unk
Correctional Facility ☐ Yes ☐ No ☐ Unk	Hospital ER ☐ Yes ☐ No ☐ Unk	Other _____
Doctors office ☐ Yes ☐ No ☐ Unk	International travel ☐ Yes ☐ No ☐ Unk	

Secondary spread

Child care ☐ Yes ☐ No ☐ Unk	Home ☐ Yes ☐ No ☐ Unk	Military ☐ Yes ☐ No ☐ Unk
Church ☐ Yes ☐ No ☐ Unk	Hospital ward ☐ Yes ☐ No ☐ Unk	School ☐ Yes ☐ No ☐ Unk
College ☐ Yes ☐ No ☐ Unk	Hospital outpatient ☐ Yes ☐ No ☐ Unk	Work ☐ Yes ☐ No ☐ Unk
Correctional Facility ☐ Yes ☐ No ☐ Unk	Hospital ER ☐ Yes ☐ No ☐ Unk	Other _____
Doctors office ☐ Yes ☐ No ☐ Unk	International travel ☐ Yes ☐ No ☐ Unk	

Worked with a case: ☐ Yes ☐ No ☐ Unk — From date: / / — To date: / /

Lived with another case: ☐ Yes ☐ No ☐ Unk — From date: / / — To date: / /

Vaccinated for pertussis? ☐ Yes ☐ No ☐ Unk

Vaccination

Date vaccinated: / /	Date vaccinated: / /	Date vaccinated: / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:
Date vaccinated: / /	Date vaccinated: / /	Date vaccinated: / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:

# of vaccinations: _____

Reason not vaccinated (check only one):

☐ Religious exemption
☐ Medical contraindication
☐ Previous disease confirmed by culture or MD
☐ Parent refusal
☐ Age less than 7 months
☐ Other _____
☐ Unknown

CONTACTS

Number of people who may have been exposed by the case: _____

Number of people prophylaxed: _____

List Contacts with symptoms. Initiate an IDSS case and start an investigation for each symptomatic contact listed.

Name	Address (if different from case)	Phone number

NOTES: