



# PERTUSSIS CASE REPORT

To be used by Local Health Jurisdictions to report to CDPH

California Dept. of Public Health  
 Immunization Branch  
 850 Marina Bay Parkway  
 Building P, 2<sup>nd</sup> Floor, MS 7313  
 Richmond, CA 94804-6403  
 Fax: (510) 620-3949

## PATIENT DEMOGRAPHICS

Patient's name (last, first, middle initial)		DOB (month / day / year) / /		Age (enter age and check one) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	
Address (number and street)		Apt #	City/town	State	Zip code
Phone number Home ( ) Work( )		Country of birth <input type="checkbox"/> USA <input type="checkbox"/> Other: / /		Date of arrival to USA / /	
Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown			Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)		
Race (check all that apply)					
<input type="checkbox"/> Black/African-American		<input type="checkbox"/> Asian (please specify)		<input type="checkbox"/> Pacific Islander (please specify)	
<input type="checkbox"/> Native American/Alaskan Native		<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Hmong	<input type="checkbox"/> Thai	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> White		<input type="checkbox"/> Cambodian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Guamanian
<input type="checkbox"/> Unknown		<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	<input type="checkbox"/> Other Asian:	<input type="checkbox"/> Samoan
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Filipino	<input type="checkbox"/> Laotian	<input type="checkbox"/> Other Pacific Islander: _____	
Occupation	Occupation Setting (check all that apply): <input type="checkbox"/> Health Care <input type="checkbox"/> Day Care <input type="checkbox"/> School <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other, specify:			Primary Language	

## CLINICAL SIGNS AND SYMPTOMS AND COURSE OF ILLNESS

Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough onset date / /	Paroxysmal cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Whoop <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Post-tussive vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cyanosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Highest recorded fever: °F/°C	
Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, describe other symptoms:			
Final interview date / /	Cough at final interview <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cough duration at final interview (in days)		Diagnosis date / /

Does case meet clinical criteria for further investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>DOES CASE MEET CDC/CSTE CLINICAL CRITERIA? (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Hospitalized (≥24 hours) <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown	Dates hospitalized / / to / /	Total # days hosp. _____ days	Died <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of death / /
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**\*If hospitalized, please complete hospitalization addendum form and attach to this report. If fatal, notify CDPH immediately.**

## TREATMENT

Were appropriate antibiotics given? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date started / /	Number of days prescribed	<b>ANTIBIOTIC TYPE:</b> <input type="checkbox"/> Erythromycin (includes pediazole) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Azithromycin <input type="checkbox"/> Trimethoprim/sulfamethoxazole <input type="checkbox"/> None <input type="checkbox"/> Clarithromycin (cotrimoxazole), i.e., bactrim/septra <input type="checkbox"/> Unknown
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## VACCINATION / MEDICAL HISTORY

Has the patient been immunized for this disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of doses <b>prior</b> to illness onset	Type of vaccine administered for last dose <input type="checkbox"/> Tdap <input type="checkbox"/> DTaP <input type="checkbox"/> DTP <input type="checkbox"/> Unknown				
Reason not vaccinated (check all that apply) <input type="checkbox"/> Personal Beliefs Exemption (PBE) <input type="checkbox"/> Permanent Medical Exemption (PME) <input type="checkbox"/> Temporary Medical Exemption <input type="checkbox"/> Lab confirmation of previous disease <input type="checkbox"/> MD diagnosis of previous disease <input type="checkbox"/> Under age for vaccination <input type="checkbox"/> Delay in starting series or between doses <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Dose 1 / / <input type="checkbox"/> Date Unknown	Dose 2 / / <input type="checkbox"/> Date Unknown	Dose 3 / / <input type="checkbox"/> Date Unknown	Dose 4 / / <input type="checkbox"/> Date Unknown	Dose 5 / / <input type="checkbox"/> Date Unknown	
	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Hospital of birth (if < 1 year old)	
	If yes, estimated date of delivery / /		Other pre-existing conditions:			

## LABORATORY INFO

<b>CASE LAB CONFIRMED (FOR LHD USE)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>CASE LAB CONFIRMED (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Culture performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Culture specimen date / /	Culture result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown			
PCR performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PCR specimen date / /	PCR result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Not Done <input type="checkbox"/> Unknown			
WBC count performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	WBC specimen date / /	WBC results (please record percent lymphocytes)			
Other lab tests performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other lab test specimen date / /	Specify other lab tests	Other lab test results		



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## EPIDEMIOLOGIC INFO

**SPREAD SETTING** (check all that apply)

<input type="checkbox"/> Day care	<input type="checkbox"/> Hospital Ward	<input type="checkbox"/> Home	<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> School	<input type="checkbox"/> Hospital ER	<input type="checkbox"/> Work	<input type="checkbox"/> Correctional facility	<input type="checkbox"/> Other _____
<input type="checkbox"/> Doctor's office	<input type="checkbox"/> Outpatient hospital clinic	<input type="checkbox"/> College	<input type="checkbox"/> Church	

Name of setting	First date of contact / /	Last date of contact / /	Contact to an infant <1 year of age? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Notes

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Epi-linked to a lab-confirmed case <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case name or case ID	Outbreak related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outbreak name or location
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## CONTACTS— this section is optional and for local health department use only

**Contacts**

	Name	Cough onset date	Relationship	Age (years)	Same household
1		/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		/ /			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Number of contacts for whom antibiotics were recommended \_\_\_\_\_ Number of ill contacts \_\_\_\_\_

## TIMELINE OF INFECTIOUSNESS AND STAGES OF COUGH – this section is optional and for local health department use only

	Exposure Period (typically 7-10 days, range 5-21 days)				Infectious Period (from onset of catarrhal stage until 5 days after antibiotic treatment or 3 weeks after cough onset)						
	WEEK	-5 weeks	-4 weeks	-3 weeks	-2 weeks	-1 week	Cough onset date	+1 week	+2 weeks	+3 weeks	
Enter dates	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	
Stages of illness	Usually no s/s of illness occur during this stage- N.A.				Catarrhal Stage (typically 1-2 weeks)		Paroxysmal Stage (may last weeks to months)				

<b>CASE CLASSIFICATION (FOR LHD USE)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown	<b>CASE CLASSIFICATION (FOR STATE USE ONLY)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
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## COMMON LHD TRACKING DATA

CMRID number	IZB case ID number		
Date reported to county / /	Date investigation started / /	Person/clinician reporting case	Reporter telephone ( )
Case investigator completing form		Investigator telephone ( )	Investigator jurisdiction

## REMARKS

### 2014 CASE DEFINITION

**Clinical case definition:** In the absence of a more likely diagnosis a cough illness lasting  $\geq 2$  weeks with one of the following symptoms:

- Paroxysm of coughing, OR
- Inspiratory "whoop," OR
- Post-tussive vomiting, OR
- Apnea (with or without cyanosis) (FOR INFANTS AGED <1 YEAR ONLY)

**Case classification**

**Confirmed:** 1) An acute cough illness of any duration with isolation of *B. pertussis* from a clinical specimen OR 2) A case that meets the clinical case definition and is confirmed by detection of *B. pertussis*-specific nucleic acid by polymerase chain reaction (PCR) OR 3) A case that meets the clinical case definition and is epidemiologically-linked directly to a laboratory-confirmed case of pertussis.

**Probable:** 1) A case that meets the clinical case definition and is not laboratory-confirmed with culture or PCR and is not epidemiologically-linked directly to a confirmed case. OR FOR INFANTS AGED <1 YEAR ONLY 2) Acute cough illness of any duration, with at least one of the following: (paroxysms of coughing, inspiratory "whoop", post-tussive vomiting, or apnea (with or without cyanosis) AND PCR positive for pertussis or contact to a laboratory-confirmed case of pertussis.

**Suspect:** 1) An acute cough illness of any duration with detection of *B. pertussis*-specific nucleic acid by PCR OR 2) An acute cough illness of any duration with at least one of the following: (paroxysms of coughing, inspiratory "whoop", or post-tussive vomiting) that is epidemiologically-linked directly to a confirmed case.