



PERTUSSIS HOSPITALIZATION ADDENDUM

To be used by Local Health Jurisdictions to report to CDPH

California Dept. of Public Health
Immunization Branch
850 Marina Bay Parkway
Building P, 2nd 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
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HOSPITALIZATION / COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized (≥ 24 hours) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Dates hospitalized / / to / /	Total # days hospitalized	Hospital name	
Name of contact	Phone	Intubated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days intubated	
Patient in ICU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days in ICU	Receive nitric oxide <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Receive exchange transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Receive ECMO <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Days on ECMO	Received medical care for pertussis prior to hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, number of medical visits	Date of first medical visit / /	
Seizures due to pertussis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chest x-ray for pneumonia <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Pulmonary hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, describe:	Death* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date of death / /		

***If died, please notify CDPH immediately**

INVESTIGATION NOTES:

CASE INVESTIGATION

Local Health Jurisdiction	Case Investigator name	LHD Case ID Number	CalREDIE Incident Number
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