



CDC • National Center for Immunization and Respiratory Diseases PERTUSSIS DEATH WORKSHEET

NEDSS ID: STATE ID:

Patient's Initials
 Date of Birth
 Date of Cough Onset
 Date of Death

Sex: Male Female
 Race*: _____ Ethnicity*: _____
 Reporting State*: _____
 Report Completed By*: _____
 Telephone Number: _____

Where did the patient die? Home Hospital En route to hospital Other (specify)Was an autopsy performed? Yes No Unknown

CHECKLIST OF DOCUMENTS TO BE SENT TO CDC

Send to: **The Pertussis Surveillance Coordinator, MS E61, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, 1600 Clifton Road NE, Atlanta Ga 30333 Fax# 404-639-8616**

No.	Document**	Yes / No
1	Pertussis case investigation form	
2	Copy of all patient's vaccination records	
3	Admission history and physical	
4	Discharge summary	
5	All medical records, including Emergency Dept notes and lab results***	
6	Death certificate	
7	Autopsy report	

PATIENT'S VACCINATION INFORMATION

Dose	Vaccine Type*	Date Administered	Manufacturer	Lot Number	Data Source ‡
<i>First</i>					
<i>Second</i>					
<i>Third</i>					
<i>Fourth</i>					
<i>Fifth</i>					
<i>Booster 1</i>					
<i>Booster 2</i>					

* Please use the same codes as in the Pertussis Case Report Worksheet

** Please obtain information from each hospital

*** Medical Chart/record also includes inpatient progress notes, x-ray reports, echocardiography reports, doctor's office notes, vaccination records, lab reports

‡ Data Source: Provider Record = 1; Parent Vaccination Card = 2; Other baby record (e.g. baby book) = 3; Parent's History (no record) = 4; Other source = 5 (please specify).

OTHER STUDIES

	Yes/ No	Date Performed	Result
<i>Chest x-ray</i>			
<i>Echocardiography</i>			

Was pulmonary hypertension a diagnosis in this patient? Yes No Unknown
 Was the patient treated with antibiotics? Yes No Unknown

If Yes please list all the antibiotics and the dates when given

Antibiotic Treatment	Date Started	Date Ended

OTHER MEDICAL AND FAMILY INFORMATION

What is the birth mother's date of birth? If unknown, what is the birth mother's age? _____

At the time of the patient's birth, did the mother have an immune suppressed or a chronic underlying medical condition? Yes No Unknown

If Yes, what is the name of the condition? _____

If the patient was <1 year old, what was the gestational age of the infant at the time of delivery? _____ weeks

What was the weight of the infant at birth? _____ lb _____ oz **or** _____ kg _____ gm

Did the patient have underlying or previous medical conditions? Yes No Unknown

If Yes, please give details _____

In the table below, list everyone who lives in the household, their date of birth, age, sex, the number of doses of pertussis-containing vaccine received and date of the last pertussis vaccine dose, smoking habits at home and the presence of a cough illness during the 3-week period prior to the cough onset date in the patient. Please indicate if pertussis was the diagnosis for the cough illness, and if so, how pertussis was confirmed.

No.	Relationship to patient	Date of birth	Age	Sex	Doses of DTP/DTaP/Tdap/P vaccine	Date of last dose	Smoking habits at home		Cough illness in family member during 3-week period prior to cough onset date in case patient			Confirmation method (Culture/ PCR/ DFA/ Serology/ None)
							Current smoker? (Yes/No)	Avg. no. of cigarettes smoked daily	Cough (Yes/No)	Cough onset date	Pertussis diagnosis? (Yes/No)	
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

During the 3-week period prior to the cough onset, was the patient exposed to anyone outside the household who was known to have a cough illness Yes No Unknown
 If Yes, List all persons who had a cough illness and who may have exposed the patient, with the dates of cough onset in the table below.

No.	Relationship to patient	Date of birth	Age	Sex	No. doses of DTP/DTaP/Tdap/DT vaccine*	Date of last dose	Cough onset date	Date cough stopped	Pertussis diagnosis	Confirmation method (Culture/ PCR/ DFA/ Serology/ None)
1										
2										
3										
4										
5										

* Indicate type of vaccine if available