State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Immunization Branch
850 Marina Bay Parkway Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Fax: (510) 620-3949

PERTUSSIS CASE REPORT FORM

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

Census Tract	County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information

Work / School Location	Work / School Contact

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	If Yes, Est. Delivery Date (mm/dd/yyyy)
Medical Record Number	Patient's Parent/Guardian Name
Occupation Setting	Other Describe/Specify
Occupation	Other Describe/Specify

Primary Language
☐ English
☐ Spanish
☐ Other: ___________________

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 10)
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.
☐ American Indian or Alaska Native
☐ Asian (check all that apply, see list on page 10)
- ☐ Asian Indian ☐ Korean
- ☐ Bangladeshi ☐ Laotian
- ☐ Cambodian ☐ Malaysian
- ☐ Chinese ☐ Pakistani
- ☐ Filipino ☐ Sri Lankan
- ☐ Hmong ☐ Taiwanese
- ☐ Indonesian ☐ Thai
- ☐ Japanese ☐ Vietnamese
- ☐ Other: ___________________

☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 10)
- ☐ Native Hawaiian ☐ Samoan
- ☐ Fijian ☐ Tongan
- ☐ Guamanian
- ☐ Other: ___________________

☐ White
☐ Other: ___________________
☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

SIGNS AND SYMPTOMS

Cough ☐ Yes ☐ No ☐ Unknown	If Yes, specify cough onset date (mm/dd/yyyy)			
Paroxysmal Cough ☐ Yes ☐ No ☐ Unknown	Whoop ☐ Yes ☐ No ☐ Unknown	Post-tussive Vomiting ☐ Yes ☐ No ☐ Unknown	Apnea ☐ Yes ☐ No ☐ Unknown	Cyanosis ☐ Yes ☐ No ☐ Unknown
Fever ☐ Yes ☐ No ☐ Unknown	If yes, then highest recorded temperature:			
Other Symptoms (describe)				

Final Interview Date (mm/dd/yyyy)	Cough at Final Interview ☐ Yes ☐ No ☐ Unknown
Cough Duration at Final Interview ☐ <14 Days ☐ >= 14 Days ☐ Unknown	

HOSPITALIZATION

Hospitalized? ☐ Yes ☐ No ☐ Unknown	Days Hospitalized		
ICU Admission ☐ Yes ☐ No ☐ Unknown			

Hospital Name	Street Address		
City	State	ZIP Code	Telephone
Admit Date (mm/dd/yyyy)		Discharge / Transfer Date (mm/dd/yyyy)	
Medical Record Number	Discharge Diagnosis		

HOSPITALIZATION COURSE

Was patient intubated? ☐ Yes ☐ No ☐ Unknown	Days Intubated	
Was patient in the ICU? ☐ Yes ☐ No ☐ Unknown	Days in ICU	
Did patient receive nitrous oxide? ☐ Yes ☐ No ☐ Unknown	Did patient receive an exchange transfusion? ☐ Yes ☐ No ☐ Unknown	
Did patient receive ECMO? ☐ Yes ☐ No ☐ Unknown	Days on ECMO	
Did patient receive medical care for pertussis prior to hospital admission? ☐ Yes ☐ No ☐ Unknown	If yes, total number of prior visits	Date of First Pertussis Medical Visit (mm/dd/yyyy)

COMPLICATIONS AND OTHER SYMPTOMS			
Seizures due to pertussis ☐ Yes ☐ No ☐ Unknown	Acute Encephalopathy ☐ Yes ☐ No ☐ Unknown	Chest X-ray for Pneumonia ☐ Yes ☐ No ☐ Unknown	Pulmonary Hypertension ☐ Yes ☐ No ☐ Unknown
Did patient have a positive laboratory test for any additional respiratory pathogens? ☐ Yes ☐ No ☐ Unknown			
Specify Pathogens:			
Bordetella parapertussis ☐ Yes ☐ No ☐ Unknown	Respiratory syncytial virus (RSV) ☐ Yes ☐ No ☐ Unknown	Influenza ☐ Yes ☐ No ☐ Unknown	Streptococcus pneumoniae ☐ Yes ☐ No ☐ Unknown
Other (Describe)			
Other Complications (Describe)			
Did patient die of this illness? ☐ Yes ☐ No ☐ Unknown			

TREATMENT / MANAGEMENT (OPTIONAL / FOR LHD USE ONLY)	
Were antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown	
ANTIBIOTIC DETAILS	
Antibiotic Type ☐ Erythromycin (includes pediazole) ☐ Trimethoprim/sulfamethoxazole (co-trimoxazole) and Bactrim/Septra ☐ Azythromycin ☐ Tetracycline/doxycycline ☐ Amoxicillin/Penicillin/Ampicillin/Augmentin/Ceclor ☐ Clarithromycin ☐ Other ☐ None ☐ Unknown	Date Started (mm/dd/yyyy)
Number of Days Prescribed	Days Antibiotics Actually Taken

VACCINATION HISTORY	
Has the patient been immunized for this disease? ☐ Yes ☐ No ☐ Unknown	
Dose #1 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #2 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #3 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #4 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #5 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Dose #6 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
If yes, specify type of vaccine administered:	
Reason Not Vaccinated: ☐ Personal Beliefs Exemption (PBE) ☐ Permanent Medical Exemption (PME) ☐ Temporary Medical Exemption ☐ Lab confirmation of previous disease ☐ MD diagnosis of previous disease ☐ Under age for vaccination ☐ Delay in starting series or between doses ☐ Unknown ☐ Other	
If other, specify:	

MEDICAL HISTORY	
Immunocompromised ☐ Yes ☐ No ☐ Unknown	Does this patient have recurrent disease with the same pathogen? ☐ Yes ☐ No ☐ Unknown
Other pre-existing conditions:	

FOR INFANT <4 MONTHS OF AGE (<12 MONTHS OF AGE OPTIONAL)	
Birthing Parent's First Name	Birthing Parent's Last Name
Birthing Parent's Middle Initial	Birthing Parent's DOB (mm/dd/yyyy)
Was the prenatal care provider available for follow up? ☐ Yes ☐ No ☐ Unknown ☐ No prenatal care received	If no, specify
Prenatal Care Provider Name (Clinician and/or Practice)	Prenatal care provider location (street, city/town, state)
Please request medical records from prenatal care provider. Were these records obtained? ☐ Yes ☐ No ☐ Unknown	If no, why?
Does prenatal care provider participate in Comprehensive Perinatal Services Program (CPSP)? ☐ Yes ☐ No ☐ Unknown	
Birthing Parent's Insurance Type for Prenatal Care ☐ Private ☐ Medi-Cal Fee for Service (Pregnancy-only) ☐ Medi-Cal Managed Care ☐ Other	
Plan Name	Member ID #
Does prenatal care provider stock Tdap on site? ☐ Yes ☐ No ☐ Unknown	If no, why not?
Did Birthing Parent receive Tdap during pregnancy? ☐ Yes ☐ No ☐ Unknown	If no, why did Birthing Parent not receive Tdap? ☐ Declined ☐ Never Recommended ☐ Other, specify below ☐ Unknown
If yes, date of Tdap vaccination? (mm/dd/yyyy)	If other, specify:
Weeks Gestation	Trimester
What is the source of prenatal Tdap information (check all that apply) ☐ Prenatal Care provider or medical staff ☐ Medical records ☐ Birthing Parent ☐ CAIR ☐ Other (specify):	
Where did Birthing Parent receive Tdap during this pregnancy? ☐ Prenatal care provider's office ☐ Pharmacy ☐ LHD or other medical office ☐ Unknown	Name of hospital where case was born
Notes	

LABORATORY RESULTS SUMMARY		
Case Lab Confirmed ☐ Yes ☐ No ☐ Unknown		
Culture Specimen Date (mm/dd/yyyy)	Culture Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Indeterminate	
PCR Specimen Date (mm/dd/yyyy)	PCR Result ☐ Positive ☐ Negative ☐ Pending ☐ Not Done ☐ Unknown ☐ Unsatisfactory	
WBC Count Performed? ☐ Yes ☐ No ☐ Unknown	WBC Specimen Date (mm/dd/yyyy)	WBC Results (Record percent lymphocytes)
If other lab tests performed, complete the following section		

Other Lab Tests		
Specify Other Lab Tests	Other Lab Test Specimen Date (mm/dd/yyyy)	Other Lab Test Results

INCUBATION PERIOD

INCUBATION PERIOD IS 21 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY (OPTIONAL)

Did patient travel during the incubation period? ☐ Yes ☐ No ☐ Unknown	Did the patient have contact with travelers or visitors during the incubation period? ☐ Yes ☐ No ☐ Unknown
Travel Type ☐ Domestic ☐ International	
State	Country
Location Details	
Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
Did patient fly while infectious? ☐ Yes ☐ No ☐ Unknown	
Airline	Flight Number
Departure Date (mm/dd/yyyy)	Arrival Date (mm/dd/yyyy)

EPIDEMIOLOGICAL EXPOSURES AND SPREAD (OPTIONAL)

Day Care ☐ Yes ☐ No ☐ Unknown	Military ☐ Yes ☐ No ☐ Unknown
Kindergarten ☐ Yes ☐ No ☐ Unknown	Correctional Facility ☐ Yes ☐ No ☐ Unknown
Grade 1-5 ☐ Yes ☐ No ☐ Unknown	Healthcare ☐ Yes ☐ No ☐ Unknown
Grade 6-8 ☐ Yes ☐ No ☐ Unknown	
High School ☐ Yes ☐ No ☐ Unknown	
College / University ☐ Yes ☐ No ☐ Unknown	
What was the student's year in school at the time of disease onset?	Was the student a member of a Greek life organization (fraternities or sororities)? ☐ Yes ☐ No ☐ Unknown
Did patient reside in a dormitory while ill? ☐ Yes ☐ No ☐ Unknown	Did patient reside in another congregate setting? ☐ Yes ☐ No ☐ Unknown
If Other setting, list:	
Provide details on setting, dates of exposure and number of close contacts:	

DOES CASE HAVE CLOSE CONTACT TO AN INFANT <12 MONTHS OF AGE OR A PREGNANT WOMAN?

If yes, details:

SPREAD SETTING	
Setting Type	Name of Setting
First Date of Contact (mm/dd/yyyy)	Last Date of Contact (mm/dd/yyyy)
Number Exposed	Notes

GENERAL CONTACTS	
Number of contacts for whom antibiotics were recommended	Number of Ill Contacts

EPIDEMIOLOGICAL LINKAGE
Was this case part of an identified cluster? ☐ Yes ☐ No ☐ Unknown
Part of known outbreak? ☐ Yes ☐ No ☐ Unknown

CASE DEFINITION (2020) - PERTUSSIS

CLINICAL CASE DEFINITION

In the absence of a more likely diagnosis, a cough illness lasting >=2 weeks with at least one of the following:
· paroxysms of coughing; **or**
· inspiratory "whoop;" **or**
· post-tussive vomiting; **or**
· apnea (with or without cyanosis)

CONFIRMED

An acute cough illness of any duration with
· Isolation of *B. pertussis* from a clinical specimen
or
· Detection of *B. pertussis*-specific nucleic acid by polymerase chain reaction (PCR)

PROBABLE

A case that meets the clinical case definition
or
An acute cough illness of any duration AND at least one of the following: whoop, paroxysm, post-tussive vomiting or apnea (with or without cyanosis) AND is a contact of a laboratory-confirmed pertussis case

Investigator Name (print)	Telephone Number
Agency Name	
Date (mm/dd/yyyy)	

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	