VPD-13
Revised August 2017

Pertussis Investigation Form

In the event of an outbreak additional forms and specimen collection are required for testing, a VIDOH-EPID staff will coordinate additional paperwork and investigation.

ISLAND: ☐ St. Croix ☐ St. John ☐ St. Thomas ☐ Water Island

FINAL STATUS: ☐ CONFIRMED ☐ PROBABLE ☐ RULED OUT/DROPPED

NBS PATIENT ID#: _____

NBS PATIENT INVESTIGATION#: _____

Patient's Name: _____ (Last First)

Address: _____

City: _____ County: _____ Zip: _____

Region: _____ Phone :( ) _____

Parent/Guardian: _____

Physician: _____Phone :( ) _____

Physician's Address: _____

_____

Reported By: _____

Agency: _____

Phone :( )_____

Date: _____/_____/_____

Report Given to: _____

Organization: _____

Phone: ( ) _____

Date: _____/_____/____

DEMOGRAPHICS:

DATE OF BIRTH: _____/_____/_____ AGE: _____ ☐Infant (<1 year old) SEX: ☐ Male ☐ Female ☐ Unknown

RACE: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pac. Islander ☐ Am. Indian or Alaska Native ☐ Unknown ☐ Other: _____

HISPANIC: ☐ Yes ☐ No ☐Unknown

CLINICAL DATA:

☐ Cough - *Onset Date:* _____/_____/_____ *Final Cough Duration* (*total* # of days) _____

At least one must be chosen to meet Confirmed or Probable case definition:

☐ Paroxysmal Cough - Onset Date: _____/_____/_____

☐ Inspiratory Whoop

☐ Vomiting after Paroxysm

☐ Apnea (Exclude Cyanotic Episode) ***For <1 year old ONLY***

Additional Symptoms

☐ Acute Encephalopathy ☐ Pneumonia: Chest X-Ray ☐ + ☐ -

☐ Cyanosis after Paroxysm ☐Other: _____

☐Seizures (Focal or Generalized)

Does patient have history of Asthma/Bronchitis? ☐ Yes ☐No

Is patient still coughing at final interview? ☐ Yes ☐ No *Date:* ____/_____/____

Hospitalized? ☐ No ☐ Yes, at: _____

Admitted: _____/_____/_____ *Discharged: _____/_____/_____ # Days_____

Physician Diagnosis:_____

**TREATMENT:*

Were antibiotics given? ☐ Yes ☐ No

☐ Azithromycin: Date Started:_____/_____/_____for _____ Days
(Z-Pak, Zithromax)

☐ Bactrim: Date Started:_____/____/_____for _____ Days
(TMP-SMX)

☐ Clarithromycin: Date Started:_____/_____/_____for _____ Days

☐ Erythromycin: Date Started:_____/_____/_____for _____ Days

☐ Other:_____ Date Started:____/____/____ for _____ Days

☐ Other:_____ Date Started:____/____/____ for _____ Days

OUTCOME: ☐ Survived ☐ Died ☐ Unknown

If Deceased, Date of Death: ____/_____/_____ ***Note:*** *A Pertussis Death Worksheet must also be submitted to DSHS.*

**Please follow up on hospitalized infants until discharge.*

LABORATORY DATA: Was laboratory testing done? ☐ Yes ☐ No ☐ Unknown

LABORATORY: ☐ DSHS ☐ Other: _____ Phone: ( ) _____

☐ PCR: Date specimen collected: _____/_____/_____ Result: _____ ☐ Equivocal ☐ Pending

☐ Culture: Date specimen collected: _____/_____/_____ Result: _____ ☐ Equivocal ☐ Pending

☐ Other: Date specimen collected: _____/_____/_____ Result: _____ ☐ Equivocal ☐ Pending

☐ Other: Date specimen collected: _____/_____/_____ Result: _____ ☐ Equivocal ☐ Pending

**Note: A four-fold rise in titer level from acute specimen to convalescent sample may be considered positive serology for pertussis. IgG results from a single specimen , IgM, IgA and DFA results are not accepted as laboratory confirmation of a suspected pertussis case.*

VACCINATION HISTORY: *CDC Objective: 90% of pertussis cases must have a vaccination history reported.*

VACCINATED: ☐ Yes ☐ No ☐ Unknown Number of doses received: _____

1 DTP: ____/____/____ *Type: _____ Manufacturer: _____ Lot #:_____

2 DTP: ____/____/____ Type: _____ Manufacturer: _____ Lot #:_____

3 DTP: ____/____/____ Type: _____ Manufacturer: _____ Lot #:_____

4 DTP: ____/____/____ Type: _____ Manufacturer: _____ Lot #:_____

5 DTP: ____/____/____ Type: _____ Manufacturer: _____ Lot #:_____

6 Tdap: ____/____/____ Type: _____ Manufacturer: _____ Lot #:_____

Use the following for vaccine type:

DTaP, DTP, Tdap, Pediarix (DTaP/ IPV/Hep B), Pentacel (DTaP/IPV/ Hib), or Kinrix (DTaP/ IPV)

If not vaccinated or has <3 doses, indicate reason: ☐ Religious Exemption ☐ Medical Contraindication ☐ Under Age ☐ Parental Refusal ☐ Unknown ☐ Other: _____

If vaccinated, please indicate:

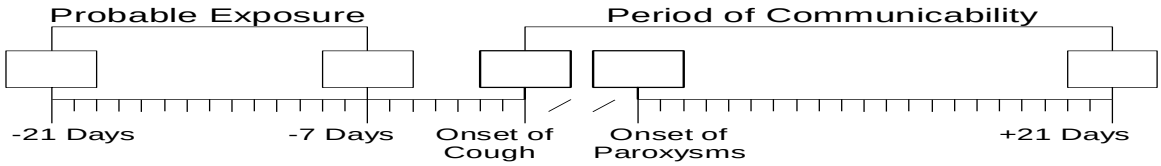
How many doses of pertussis-containing vaccine were given more than 2 weeks before illness onset? _____

Date of Last Pertussis-Containing Vaccine Before Illness : _____/_____/_____

For cases <1, was the mother given Tdap? ☐At Delivery ☐Postpartum ☐During Pregnancy ☐Unknown ☐Not Vaccinated during or after pregnancy (within 1 month) Date received: _____/_____/_____

If date unknown: ☐2nd Trimester ☐3rd Trimester ☐Vaccinated at delivery ☐Vaccinated after delivery >1 day

INFECTION TIMELINE: ***Enter onset of cough. Count backwards and forwards to enter dates for probable exposure and communicable periods.***



SOURCE OF INFECTION: ☐ No exposure identified ☐ Close contact with a known or suspected case ☐Household exposure

Name	*Age*	*Cough Onset*	*How many doses of pertussis-containing vaccine has this suspected source received?*	*Phone*	*NBS Case No.*
_____	____	____/____/____	_____	( )_____	_____

☐ *Is case epidemiologically linked to a lab-confirmed case?* ☐ Yes ☐ No ☐ Unknown NBS Case # _____

☐ *Where did this case acquire pertussis?:* ☐ Day-care ☐ School ☐ College ☐ Work ☐ Home ☐ Dr Office ☐ Hospital ER

☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Military ☐ Jail ☐ Church ☐ Travel ☐ Unknown ☐ Other: _____

*Name(s) of Setting:*_____

☐ *Has any travel occurred within the exposure period?* ☐ Yes ☐ No ☐ Unknown *If yes, list location:* _____

☐ *Is case part of an outbreak*?* ☐ Yes ☐ No ☐ Unknown *If yes, list outbreak name*: _____

****Outbreaks must be 3 or more cases in the same setting with cough onsets within a 3 week period***

Did patient attend school/daycare? ☐Yes ☐No ☐Unknown *If yes, which school/daycare: _____Grade: ____Teacher's name_____*

Transportation to school: ☐Walk ☐Carpool ☐Car ☐Bus#_____ *Last date of attendance: ____/____/____ Date Returned: ____/____/____*

After school care: _____ Other after school activities: _____ Where: _____

Did patient attend any of the following while symptomatic?: ☐Sleepover ☐Church activities ☐Babysit ☐Visit hospital patient

HOUSEHOLD CONTACTS: *Were control activities initiated?:* ☐ Yes ☐ No ☐ Unknown *If no, explain: _____*

Name	*Relation to Case*	*Age*	*Vaccination HX*	***Symptoms/Date of Onset*	*Type of Prophylaxis/Date Treated*

Number of contacts recommended to receive antibiotics prophylaxis: _____

Antibiotic prophylaxis is recommended for household and high-risk contacts (infants, contacts of infants, immunocompromised)

Investigations should be completed on all symptomatic contacts of confirmed or probable cases

POSSIBLE SPREAD CONTACTS:

Setting: ☐ No Spread ☐ Day-care ☐ School ☐ College ☐ Work ☐ Home ☐ Dr. Office ☐ Hospital ER ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Military ☐ Jail ☐ Church ☐Travel ☐ Unknown ☐ Other: _____

Name (s) of Settings: _____

Name	*Relation to Case*	*Age*	*Vaccination HX*	***Symptoms/Date of Onset*	*Type of Prophylaxis/Date Treated*

Investigations should be completed on all contacts with symptoms

PROVIDED INFORMATION TO PATIENT:

☐Vaccinations for Contacts/Household (most effective way to prevent pertussis) ☐ Transmission (person-person; by breathing in the bacteria)

☐Daycare/school restriction, if applicable (may return after 5 days of antibiotics) ☐Other_____

CDC Objective: 90% of vaccine preventable cases must be investigated and reported to the CDC within 30 days of initial report.

Date Investigation Initiated: _____/_____/_____ Date Investigation Completed: ____/_____/____Date Reported to DSHS: ____/_____/____

Investigator's Name: _____ Agency name: _____ Phone :( ) _____

Closed in NBS? ☐ Yes ☐ No If confirmed or probable, notification submitted? ☐ Yes ☐ No

COMMENTS/NOTES