Infectious Disease Control Unit, Texas Department of State Health Services
P.O. Box 149347, MC 1960
Austin, Texas 78714
Phone: (512) 776-7676 Fax: (512) 776-7616
VPDTexas@dshs.texas.gov

Pertussis Case Track Record

FINAL STATUS:
☐ CONFIRMED
☐ PROBABLE
☐ RULED OUT /NOT A CASE

NBS PATIENT ID#: ______________________________

NBS INVESTIGATION ID#: ______________________________

Patient's Name: ____
last first

Address: ____

City: ____________________ County: ______________ Zip: __________

Region: ________ Phone: ( ) ______________________________

Parent/Guardian: ____

Physician: ________________________ Phone: ( ) ______________

Address: ____

____

☐ Check box if history of homelessness in last 6 months

Reported by: _________________________________

Agency: _____________________________________

Phone: ( )_____________

Date reported: ____/____/____

Investigated by: _____________________________

Agency: _____________________________________

Phone: ( ) _______________

Email:_______________________________________

Investigation start date: ____/____/____

Date investigation completed: ____/____/____

DEMOGRAPHICS: *DATE OF BIRTH:* _____/_____/_____ *AGE:* ________ *PLACE OF BIRTH*: ☐ USA ☐ Other:___________ ☐ Unknown

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

Was the patient <12 months old? ☐ Yes ☐ No If yes, Mother's age at date of infant birth: _______

Infant birth weight: _____lbs _____oz OR _____g OR ☐ Unknown

If female, is patient currently pregnant? ☐ Yes ☐ No ☐ Unknown Obstetrician's name, address, and phone #: ______________________

If yes, estimated date and location of delivery: ____/____/____ ____

CLINICAL DATA:

Symptom onset date: ____/____/____

Diagnosis date: ____/____/____

Illness end date: ____/____/____

Final Cough Duration (total # of days): ______ Days

Symptoms:

Symptom	
Paroxysmal Cough	☐Yes / ☐No
Inspiratory Whoop	☐Yes / ☐No
Post-tussive Vomiting	☐Yes / ☐No
Apnea (exclude cyanotic episode) (under 1 yr old only)	☐Yes / ☐No

Is the patient still coughing at final interview?.................. ☐Yes / ☐No

Date of final interview: ____/____/____

Additional Symptoms:

Symptom	
Acute Encephalopathy	☐Yes / ☐No
Cyanosis after Paroxysm	☐Yes / ☐No
Seizures (Focal or Generalized)	☐Yes / ☐No
Pneumonia Chest X-Ray	☐Yes / ☐No
Other _________________	☐Yes / ☐No

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

TREATMENT:

Were antibiotics given? ☐Yes / ☐No

☐ Azithromycin: Date Started:____/____/____ for _____ Days
☐ Bactrim: Date Started:____/____/____ for _____ Days
☐ Clarithromycin: Date Started:____/____/____ for _____ Days
☐ Erythromycin: Date Started:____/____/____ for _____ Days
☐ Other:________Date Started:____/____/____ for _____ Days
☐ Other:________Date Started:____/____/____ for _____ Days

Was the patient hospitalized for this illness? ☐Yes / ☐No

Hospitalized at: ____________________________

Admitted: ____/____/____ Discharged: ____/____/____

Duration of Stay: _________days

Did patient die? ☐ Yes*, died on: ____/____/_____
☐ No
☐ Unknown

**If patient is <1 yr old, please fill out and fax the Pertussis Death Worksheet to 512-776-7616.*

Patient History – Pertussis Pt. Name:________________________ NBS Pt. ID:______________

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

LABORATORY: ☐ DSHS ☐ Other: ____

Ordering Provider: _______________________ Reporting Facility:________________________________

☐ PCR: Date specimen collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

☐ Culture: Date specimen collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

☐ Other: Date specimen collected: _____/_____/_____ Result: ________ Lab Report Date: _____/_____/_____

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

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

1st Dose: ____/____/____ Type: ___________________________ Manufacturer: _________________ Lot #:____________________

2nd Dose: ____/____/____ Type: ___________________________ Manufacturer: _________________ Lot #:____________________

3rd Dose: ____/____/____ Type: ___________________________ Manufacturer: _________________ Lot #:____________________

4th Dose: ____/____/____ Type: ___________________________ Manufacturer: _________________ Lot #:____________________

5th Dose: ____/____/____ Type: ___________________________ Manufacturer: _________________ Lot #:____________________

6th Dose: ____/____/____ 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? ________

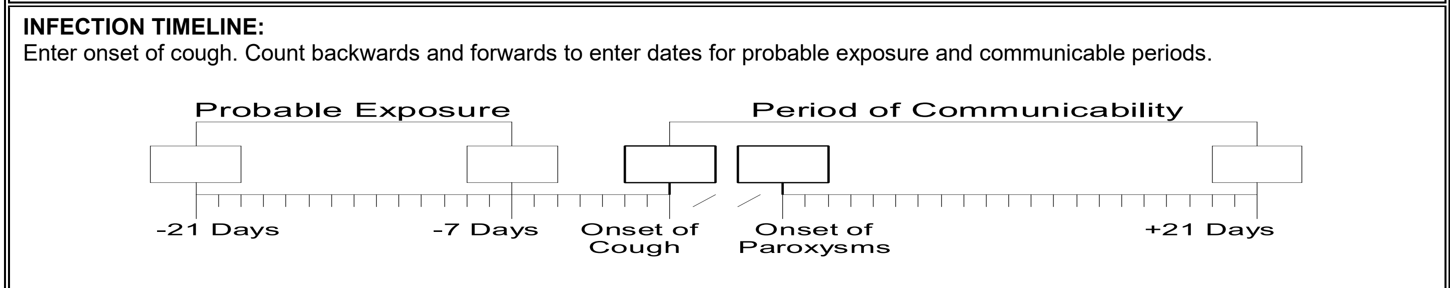
Date of last pertussis-containing vaccine before illness: _____/_____/_____

For cases <1 year of age, was the mother given Tdap? ☐Yes / ☐No **Date Received: _____/_____/_____**

If yes, when? ☐ At Delivery ☐ Postpartum ☐ During Pregnancy ☐ Unknown

If date is 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: NBS Pt ID:________________

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: _______________________

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: ____

TRANSMISSION LOCATIONS:

Did the case-patient attend school/daycare? ☐Yes / ☐No

If yes, which school/daycare? ____________________________ Grade: _____ Teacher: ______________________

Last date of attendance: _____/_____/_____ Date Returned: _____/_____/_____

Transportation to school: ☐ Walk ☐ Carpool ☐ Car ☐ Bus# _____ ☐ Other ____________________

After school care: ___________________ Other after school activities: _____________________

Did the case-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***

ADDITIONAL 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***

COMMENTS: