Pertussis PEP Client Evaluation Form
(to be placed into medical record)

Client Name: _____ Date of Birth: _____

Client Address: _____

City: _____ State: _____ Zip Code: _____

Pertussis Vaccination History: Date of Last Pertussis Vaccination: _____ Vaccination current? ☐ Yes ☐ No ☐ Unknown

If no or unknown, referred to ☐ DSHS ☐ other _____

Personal Health History:

☐ Personal Health History not completed as client not eligible for pertussis PEP from DSHS.

Medication Allergies: _____

Current Medications: _____

Chronic Health Conditions: _____

For females of childbearing potential, currently pregnant? ☐ Yes ☐ No

Current symptoms: ☐ Yes ☐ No If yes, list: _____

Limited Physical Exam:

☐ Limited Physical Exam not completed as client not eligible for pertussis PEP from DSHS.

Vital Signs: Weight (if a child): _____ Temperature: _____

General Inspection: ☐ Normal ☐ Abnormal If abnormal, describe: _____

Any other relevant signs of client's status: _____

Nursing Care Rendered and Actions Carried Out Under Standing Delegation Orders:

Check box to indicate the following forms are completed (and signed by client where indicated) and included in the medical record:

☐ ***DSHS General Consent and Disclosure***

☐ ***Pertussis PEP Medication Contraindications and Precautions Checklist*** ☐ Not Applicable

☐ ***Pertussis PEP Eligibility Criteria Checklist***

☐ If client eligible to continue evaluation for pertussis PEP, checklist faxed to DSHS Emerging and Acute Infectious Disease Branch at (512) 776-7103.

Check box to indicate the following forms have been provided to the client:

☐ ***DSHS Privacy Notice***

☐ ***Pertussis Information Sheet***

☐ ***Azithromycin for Pertussis PEP Fact Sheet*** ☐ Not Applicable

☐ ***TMP-SMZ for Pertussis PEP Fact Sheet*** ☐ Not Applicable

Pertussis PEP provided: ☐ azithromycin ☐ TMP-SMZ ☐ none ☐ did not meet eligibility criteria

Any Additional Physician Orders: _____

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TEXAS Department of State Health Services

Texas Department of State Health Services
Immunization Branch

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Client Responses, if any:

Contacts with other healthcare team members concerning significant events regarding client's status:

Description of other nursing care rendered:

Names of other personnel involved in evaluation and treatment, including interpreter, if applicable:

Nurse's Name:

Nurse's Signature: Date: