Pertussis PEP Eligibility Criteria Checklist

Client's Name: _____ Client's Date of Birth: _____

Client's County of Residence: _____

Case Name: _____ Date of Assessment: _____

Name of Nurse and Jurisdiction Performing Assessment: _____

Signature of Nurse Performing Assessment: _____

Section 1: Criteria Items for Confirmed Close or High Risk Contacts to a Pertussis Case:	**Yes**	**No**
Has the client been exposed to pertussis within the last 21 days?	☐	☐

If box in Section 1 is checked Yes, continue to next section.
If the answer is No, the client is not eligible for pertussis PEP.
Do not continue to next section. Stop.

Section 2: Criteria Items for Confirmed Close or High Risk Contacts to a Pertussis Case:	**Yes**	**No**
Is the client coughing?	☐	☐
Does the client live in the same house as the case?	☐	☐
If no, how many individuals live in the client's home? _____		
Is the client at high risk of severe illness?	☐	☐
Will the client have close contact with someone at high risk of severe illness?	☐	☐
High risk of severe illness includes: (check the applicable boxes)		
• Infant under 12 months	☐	☐
If yes, name and date of birth of infant (if known):_____		
• Woman in her third trimester of pregnancy	☐	☐
• Person with preexisting health conditions that may be exacerbated by a pertussis infection (for example, immunocompromised persons or moderate to severe medically treated asthma)	☐	☐

If at least one box in Section 2 is checked Yes, continue to next section.
If all answers in Section 2 are No, the client is not eligible for pertussis PEP.
Do not continue to next section. Stop.

Section 3: Criteria Items for Confirmed Close or High Risk Contacts to a Pertussis Case:	**Yes**	**No**
Is the client unable to access medical care within a reasonable time period to prevent disease spread?	☐	☐
Does the client lack financial resources to pay for medical care or PEP, based on the information provided by the client?	☐	☐
Has the client's medical provider given guidance/recommendations for pertussis PEP that vary from DSHS and CDC recommendations?	☐	☐

If at least one box in Section 3 is checked Yes, *complete next section at end of client visit.*
If all answers in Section 3 are No, the client is not eligible for pertussis PEP *from DSHS*. Do not continue to next section. Stop.

Final Disposition: Pertussis PEP provided ☐Azithromycin Tablets ☐ TMP-SMZ Tablets ☐ none

☐Azithromycin Suspension (# of bottles____) ☐ TMP-SMZ Suspension

Fax this form to the DSHS Emerging and Acute Infectious Disease Branch at (512) 776-7103.