

Pertussis

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____
 Referred to another state: _____

CASE

Last name: _____
 First and middle name: _____
 Maiden name: _____ Suffix: _____
 Address line: _____
 Zip: _____ City: _____
 State: _____ County: _____
 Phone: ()- - Type: _____
 Long-term care resident: Yes No Unknown
 Facility name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____
 Gender: Female Male Other _____
 Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____
 Marital status: Single Married Divorced Parent with partner Separated Widowed
 Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian
 Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
 Parent/Guardian name: _____
 Parent/Guardian phone: ()- - Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____
 Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown
 Outbreak related: Yes No Unknown
 Outbreak name: _____
 Exposure setting: _____
 Epi-linked: Yes No Unk To whom: _____
 Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown
 State: _____ Country: _____

Healthcare provider information

Last name: _____
 First name: _____
 Provider title: ARNP MD DO NP PA
 Facility name: _____
 Address line 1: _____
 Address line 2: _____
 Zip code: _____ City: _____
 State: _____ County: _____
 Phone : ()- - Type: _____

LABORATORY FINDINGS

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: <input type="checkbox"/> Culture <input type="checkbox"/> PCR
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Negative <input type="checkbox"/> No growth <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Equivocal
Organism: _____		

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Organism: _____		

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Job title: _____ Facility name: _____
Date worked from: ____/____/____ Date worked to: ____/____/____ Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Address: _____ Zip code: _____ City: _____ State: _____ County: _____
Date removed: ____/____/____ Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Phone: (____)____-____-____ Type: _____ Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Health care worker type: _____

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HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

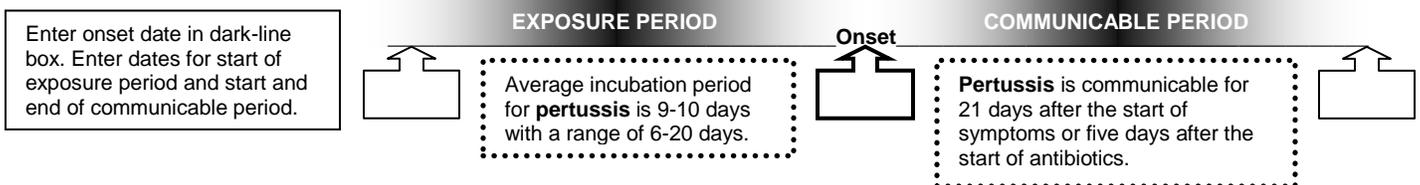
Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____/____/____	Discharge date: ____/____/____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

Note: The cough duration, cough type, and symptoms must be documented for IDPH to status case.

Symptoms	Cough: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Cough type: <input type="checkbox"/> Paroxysmal <input type="checkbox"/> Whoop <input type="checkbox"/> Other	Onset Date: ____/____/____
	Symptoms: <input type="checkbox"/> Apnea event <input type="checkbox"/> Pneumonia <input type="checkbox"/> Post-tussive vomiting <input type="checkbox"/> Seizures <input type="checkbox"/> None listed above	Chest X-ray done: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk X-ray date: ____/____/____	X-ray result: _____
	Pneumonia: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Final interview date: ____/____/____	Encephalopathy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
			Cough at final interview: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Duration in days: _____

INFECTION TIMELINE



TREATMENT

Antibiotics prescribed? Yes No Unknown

Antibiotic: _____
 Date started: ____ / ____ / ____
 Dose: _____
 mg
 ml IU # of days: _____
 # of times a day: _____ Route: _____

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 Dose: _____
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 ml IU # of days: _____
 # of times a day: _____ Route: _____

RISK FACTORS/TRAVEL

Traveled within Iowa? Yes No Unk City in Iowa: _____ Departure date: ____ / ____ / ____ Return date: ____ / ____ / ____
 Traveled within U.S.? Yes No Unk State: _____ City: _____ Departure date: ____ / ____ / ____ Return date: ____ / ____ / ____
 Traveled outside U.S.? Yes No Unk Country: _____ Departure date: ____ / ____ / ____ Return date: ____ / ____ / ____

Setting Acquired	Child care <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Home <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Military <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Church <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Hospital ward <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	School <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Secondary spread	College <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Hospital outpatient <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
	Correctional Facility <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Hospital ER <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other _____
	Doctors office <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	International travel <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
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Worked with a case: Yes No Unk From date: ____ / ____ / ____ To date: ____ / ____ / ____

Lived with another case: Yes No Unk From date: ____ / ____ / ____ To date: ____ / ____ / ____

Vaccinated for pertussis? Yes No Unk

Vaccination	Date vaccinated: ____ / ____ / ____	Date vaccinated: ____ / ____ / ____	Date vaccinated: ____ / ____ / ____
	Lot #: _____	Lot #: _____	Lot #: _____
	Vaccine type: _____	Vaccine type: _____	Vaccine type: _____
	Manufacturer: _____	Manufacturer: _____	Manufacturer: _____
	Date vaccinated: ____ / ____ / ____	Date vaccinated: ____ / ____ / ____	Date vaccinated: ____ / ____ / ____
	Lot #: _____	Lot #: _____	Lot #: _____
	Vaccine type: _____	Vaccine type: _____	Vaccine type: _____
	Manufacturer: _____	Manufacturer: _____	Manufacturer: _____

of vaccinations: _____

Reason not vaccinated (check only one):

<input type="checkbox"/> Religious exemption	<input type="checkbox"/> Age less than 7 months
<input type="checkbox"/> Medical contraindication	<input type="checkbox"/> Other _____
<input type="checkbox"/> Previous disease confirmed by culture or MD	<input type="checkbox"/> Unknown
<input type="checkbox"/> Parent refusal	

