



DEPARTMENT OF HEALTH

Infectious Disease Epidemiology and Outbreak Response Bureau
Maryland Department of Health
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Pertussis Case Report Form
FINAL STATUS:
CONFIRMED
PROBABLE
RULED OUT /NOT A CASE
NEDSS PATIENT ID#:
NEDSS INVESTIGATION ID#:

Patient's Name: last first
Address:
City: County: Zip:
Phone:
Parent/Guardian:
Physician: Phone:
Physician Address:
Reported by:
Phone:
Date reported: / /
LHD Investigator:
LHD:
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 Infant birth weight: lbs oz OR g OR Unknown
If female, is patient currently pregnant? Yes No Unknown

CLINICAL DATA: Symptom onset date: / / Paroxysmal cough onset date: / / Diagnosis date: / / Illness end date: / / Final Cough Duration (total # of days): Days
Symptoms: 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 Clinical Information: 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
Hospital:
Admitted: / / Discharged: / /
Duration of Stay: days
Did patient die? Yes*, died on: / / No Unknown

Pt. Name: _____

NEDSS Pt. ID: _____

LABORATORY DATA: Was laboratory testing done? Yes No Unknown

LABORATORY: MDPHL Other: _____

Ordering Provider: _____ Reporting Facility: _____

PCR: Specimen: _____ Date specimen collected: ____/____/____ Result: _____ Lab Report Date: ____/____/____

Culture: Specimen: _____ Date specimen collected: ____/____/____ Result: _____ Lab Report Date: ____/____/____

Other: Specimen: _____ Date specimen collected: ____/____/____ Result: _____ Lab Report Date: ____/____/____

VACCINATION HISTORY:

VACCINATED: Yes No Unknown Number of doses received: _____

1st Dose: ____/____/____ Type: _____

2nd Dose: ____/____/____ Type: _____

3rd Dose: ____/____/____ Type: _____

4th Dose: ____/____/____ Type: _____

5th Dose: ____/____/____ Type: _____

6th Dose: ____/____/____ Type: _____

Use the following for vaccine type:

DTaP, DTP, Tdap

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

SOURCE OF INFECTION: No exposure identified Close contact with a known or suspected case: NEDSS Pt ID: _____

Where did this case acquire pertussis (if known)? _____

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 number: _____

TRANSMISSION LOCATIONS:

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

If yes, which school/daycare? _____ Grade/Class: _____ 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 visit any other settings where they might have exposed others during their infectious period (e.g., sleepover, healthcare visit)? If yes, please describe:

