

Infectious Disease Epidemiology and Outbreak Response Bureau Maryland Department of Health 201 W Preston St, 3rd Floor Baltimore, Maryland 21201

Phone: (410) 767-6700 Fax: (410) 333-5893

		FINIAL CTATU	INAL STATUS:		NEDSS PATIENT ID#:			
Pertussis Case Report Form		□ CONFIRME	_					
•		☐ PROBABLE						
			T /NOT A CASE		NEDSS INVESTIGATION ID#:		ΓΙΟΝ ID#:	
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	07.02				
Patient's Name:	rst		Repor	ted by:				
Address:				:				
City: County:				eported:				
Phone:			LHD Ir	nvestigator:				
Parent/Guardian:								
Physician: Phone:			Phone	:				
Physician Address:			Email:					
		<del> </del>	Investi	gation start d	late:/	/		
			Date in	nvestigation o	completed:	<u>//</u>	_	
DEMOGRAPHICS: DATE OF BIRTH://	_ AGE:	PLAC	E OF BIF	RTH: 🗆 USA	☐ Other:	U	nknown	
SEX: □ Male □ Female □ Unknown								
RACE: □ White □ Black □ Asian □ Native Hawaiian c	or Other Pac	. Islander □ An	n. Indian	or Alaska Nat	ive  Unknown	Other:_		
HISPANIC: □Yes □No □Unknown								
Was the patient <12 months old? $\Box$ Yes $\Box$ No Infant bir	th weight: _	lbso	oz OR _	g OR □	Unknown			
If female, is patient currently pregnant? □Yes □No □Unkno	own							
CLINICAL DATA:		TREATM						
Symptom onset date://		Were anti	biotics g	iven? □	Yes / □No			
Paroxysmal cough onset date://						_	_	
Diagnosis date:/			-		d:/			
Illness end date://		□ Bactrim			d://			
Final Cough Duration (total # of days): Days					d://_			
Symptoms:	ПУ00 / ПП	-	-		d://_			
Paroxysmal Cough	□Yes / □I	_			d://_			
Inspiratory Whoop	□Yes / □I			_Date Starte	d://_	for	Days	
Post-tussive Vomiting	□Yes / □I							
Apnea (exclude cyanotic episode) (under 1 yr old only)	□Yes / □I							
Is the patient still coughing at final interview?	□Yes / □I	Was the p	patient l	nospitalized	for this illness	<b>?</b> □Yes/	□No	
Date of final interview:/		Hospital: _				_		
<del></del>		Admitted:	/	_/ Disch	arged:/	_/		
Additional Clinical Information:			f Stay: _	days	S			
Acute Encephalopathy	□Yes / □I							
Cyanosis after Paroxysm	□Yes / □I	Dia patie	nt die?	□Yes*, died	d on:/	/		
Seizures (Focal or Generalized)	□Yes / □I			□ No				
Pneumonia Chest X-Ray	□Yes / □I			☐ Unknown	1			
Other	□Yes / □I	No						
Does patient have history of Asthma/Bronchitis?	□Yes / □	No						

	L □Other:			<del> </del>		
	Reporting Facili					,
	Date specimen collecte				<del></del>	
	Date specimen collecte Date specimen collecte					
Liother: Specimen	Date specimen collecte	/	/	Result:	Lab Report Date:	/
VACCINATION HISTORY						
VACCINATED: □Yes	☐ No ☐ Unknown	Numb	er of do	ses received:		
1 <sup>st</sup> Dose:/	Type:					
2 <sup>nd</sup> Dose://	Type:					
3 <sup>rd</sup> Dose://	Type:			<del></del>		
4 <sup>th</sup> Dose://	Type:			<del> </del>		
5 <sup>th</sup> Dose://	Type:			<del> </del>		
6 <sup>th</sup> Dose://	Type:					
	Use the following t	for vaccine t	type:			
	DTaP, DT	P. Tdap				
	ery □ Postpartum □ During Pregr □2 <sup>nd</sup> Trimester □3 <sup>rd</sup> Trimester □\			□Vaccinated aff	er delivery >1 day	
If date is unknown, [  SOURCE OF INFECTION: Where did this case acquire	□ No exposure identified □ pertussis (if known)?	/accinated at	Delivery	a known or suspe	ected case: NEDSS Pt ID:_	
If date is unknown, [  SOURCE OF INFECTION: Where did this case acquire Has any travel occurred wit	□ No exposure identified □ pertussis (if known)? □ Hone the period? □ Yes □ Period? □ P	/accinated at  Close conta	Delivery  act with a	a known or suspe	ected case: NEDSS Pt ID:_	
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SOURCE OF INFECTION: Where did this case acquire Has any travel occurred wit s case part of an outbreak  TRANSMISSION LOCATIO Did the case-patient attend If yes, which school	□No exposure identified □ e pertussis (if known)? hin the exposure period? □Yes □ e □Yes □No □Unknown If y ends:	Close contains of the contains	act with a cown If you eak num	a known or suspe es, list location: _ nber: Class:	ected case: NEDSS Pt ID:_	
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Pt. Name:\_\_\_\_\_

NEDSS Pt. ID:\_\_\_\_\_

OUSEHOLD CONTACTS:					
ame	Relation to Case	Age	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated	
····					
				·	
			<u> </u>		
ibiotic prophylaxis is re	ecommended for h	ouseho	old and high-risk contacts (i	infants, contacts of infants, immur	nocompromise
vestigations should be	completed on all sy	ympton	natic contacts of confirmed	or probable cases	
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DITIONAL CONTACTS:					
tting type:					
ang type.		-			
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	Relation to Case	Age	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated	
	Relation to Case	Age 	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated	
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	Relation to Case	Age	*Symptoms/Date of Onset	Type of Prophylaxis/Date Treated	
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NEDSS Pt. ID:\_\_\_\_\_

Pt. Name:\_\_\_\_\_