

Pertussis Surveillance Worksheet

NAME	ADDRESS (Street and No.)	Phone	Hospital Record No.																																				
(last)	(first)																																						
This information will not be sent to CDC																																							
REPORTING SOURCE TYPE	NAME	SUBJECT ADDRESS CITY																																					
<input type="checkbox"/> physician <input type="checkbox"/> PH clinic	ADDRESS	SUBJECT ADDRESS STATE																																					
<input type="checkbox"/> nurse <input type="checkbox"/> laboratory	ZIP CODE	SUBJECT ADDRESS COUNTY																																					
<input type="checkbox"/> hospital <input type="checkbox"/> other clinic	PHONE (____) _____	SUBJECT ADDRESS ZIP CODE																																					
<input type="checkbox"/> other source type _____		LOCAL SUBJECT ID																																					
CASE INFORMATION																																							
Date of Birth ____-____-____ month day year	Country of Birth _____	Other Birth Place _____	Country of Usual Residence _____																																				
Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not asked <input type="checkbox"/> Refused to answer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown																																							
Ethnic Group H=Hispanic or Latino N=Not Hispanic/Latino O=Other _____ U=Unknown <input type="checkbox"/>		Sex M=male F=female U=unknown <input type="checkbox"/>																																					
Age at Case Investigation _____	Age Unit* _____	Reporting County _____	Reporting State _____																																				
Date Reported ____-____-____ month day year	Date First Reported to PHD ____-____-____ month day year	National Reporting Jurisdiction _____																																					
Earliest Date Reported to County ____-____-____ (mm/dd/yyyy)		Earliest Date Reported to State ____-____-____ (mm/dd/yyyy)																																					
Case Class Status <input type="checkbox"/> Suspected <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> Unknown <input type="checkbox"/> Not a case		Case Investigation Start Date ____-____-____ month day year																																					
Case Detection Method <input type="checkbox"/> prenatal testing <input type="checkbox"/> prison entry <input type="checkbox"/> provider report <input type="checkbox"/> routine physical <input type="checkbox"/> self-referral <input type="checkbox"/> other _____ <input type="checkbox"/> unknown																																							
Case Investigation Status Code <input type="checkbox"/> approved <input type="checkbox"/> closed <input type="checkbox"/> deleted <input type="checkbox"/> in progress <input type="checkbox"/> notified <input type="checkbox"/> other _____ <input type="checkbox"/> rejected <input type="checkbox"/> reviewed <input type="checkbox"/> suspended <input type="checkbox"/> unknown																																							
CLINICAL INFORMATION																																							
Illness Onset Date ____-____-____ month day year	Illness End Date ____-____-____ month day year	Illness Duration ____	Duration Units* _____																																				
Hospitalized? Y=yes N=no U=unknown <input type="checkbox"/>	Hospital Admission Date ____-____-____ month day year	Hospital Discharge Date ____-____-____ month day year																																					
Duration of Hospital Stay 0-998 _____ 999=unknown (days)	Date of Diagnosis ____-____-____ month day year	Pregnancy Status Y=yes N=no U=unknown <input type="checkbox"/>																																					
SIGNS AND SYMPTOMS		COMPLICATIONS																																					
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th>U</th> </tr> </thead> <tbody> <tr> <td>Apnea</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Cough</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Cyanosis</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Paroxysmal cough</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p style="text-align:center;">Y=yes N=no U=unknown</p>			Y	N	U	Apnea				Cough				Cyanosis				Paroxysmal cough				<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Y</th> <th>N</th> <th>U</th> </tr> </thead> <tbody> <tr> <td>Encephalopathy</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other _____</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p style="text-align:center;">Y=yes N=no U=unknown</p>			Y	N	U	Encephalopathy				Seizures				Other _____			
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Cough Onset Date ____-____-____ (mm/dd/yyyy) month day year	Age at Cough Onset <input type="text"/> <input type="text"/> <input type="text"/>	Age Unit* _____																																					
Total Cough Duration <input type="text"/> <input type="text"/> <input type="text"/> (days)	Was there a cough at patient's final interview? Y=yes N=no U=unknown <input type="checkbox"/>																																						
Date of Final Interview ____-____-____ month day year	Subject died? Y=yes N=no U=unknown <input type="checkbox"/>	Deceased Date ____-____-____ month day year																																					
Chest X-Ray for Pneumonia P=positive N=negative X=not done U=unknown <input type="checkbox"/>		Were antibiotics given? Y=yes N=no U=unknown <input type="checkbox"/>																																					
*UNITS a=year d=day h=hour min=minute mo=month s=second wk=week UNK=unknown																																							

TREATMENT

First Antibiotic Received

Date Treatment Initiated _____
month day year

Treatment Duration (days)

ANTIBIOTIC(S) GIVEN

1 = amoxicillin 2 = amoxicillin-potassium clavulanate combination 3 = ampicillin 4 = azithromycin 5 = ceftriaxone 6 = cefuroxime
 7 = ciprofloxacin 8 = other _____ 9 = unknown 10 = clarithromycin 11 = doxycycline 12 = erythromycin
 13 = none 14 = penicillins 15 = trimethoprim-sulfamethoxazole 16 = tetracycline

Second Antibiotic Received

Date Treatment Initiated _____
month day year

Treatment Duration (days)

LABORATORY INFORMATION

VPD Lab Message Reference Laboratory _____

VPD Lab Message Patient Identifier _____

VPD Lab Message Specimen Identifier _____

Was Laboratory Testing Done to Confirm Diagnosis? Y=Yes N=No U=Unknown

Was Case Laboratory Confirmed? Y=yes N=no U=unknown Was a Specimen Sent to CDC for Testing? Y=yes N=no U=unknown

Test Type	Test Result	Date Specimen Collected	Test Result Quantitative	Result Units	Specimen Source	Date Specimen Sent to CDC	Specimen Analyzed Date	Performing Laboratory Type
		<small>month day year</small>				<small>month day year</small>		
IgA		_____				_____	_____	
IgM		_____				_____	_____	
IgG (acute)		_____				_____	_____	
IgG (conv)		_____				_____	_____	
IgG EIA (unspec)		_____				_____	_____	
IgG toxin		_____				_____	_____	
culture		_____				_____	_____	
DFA		_____				_____	_____	
PCR		_____				_____	_____	
genotype		_____				_____	_____	
other test type		_____				_____	_____	
unspecified serology		_____				_____	_____	
unknown		_____				_____	_____	

Lab Test Interpretation Codes

Specimen Source Codes

BP= <i>Bordetella parapertussis</i> BS= <i>Bordetella</i> species P=positive N=negative E=pending X=not done S=significant rise in titer NS=no significant rise in titer I=Indeterminate Q=equivocal O=other (specify) U=unknown	1=bacterial isolate 10=cataract 19=nasopharyngeal isolate 28=scab 37=nasal sinus 2=blood 11=CSF 20=nasopharyngeal swab 29=serum 38=vesicula swab 3=body fluid 12=lesion 21=nasopharyngeal washing 30=skin lesion 39=internal nose 4=bronchoalveolar lavage 13=microbial isolate 22=nucleic acid 31=specimen 40=throat 5=buccal smear 14=crust 23=oral fluid 32=lung 41=tissue 6=buccal swab 15=DNA 24=oral swab 33=lavage 42=urine 7=capillary blood 16=lesion 25=plasma 34=stool 43=vesicle fluid 8=other (specify) 17=macular scraping 26=RNA 35=swab 44=viral isolate 9=unknown 18=microbial isolate 27=saliva 36=skin lesion swab
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Performing Laboratory Type 1=CDC lab 2=commercial lab 3=hospital lab 4=other clinical lab 5=public health lab 6=VPD testing lab 8=other 9=unknown

VACCINATION HISTORY INFORMATION

VACCINATED (has the case-patient ever received a vaccine against this disease) ? Y=yes N=no U=unknown

Was the subject vaccinated per ACIP recommendations? Y=yes N=no U=unknown

Number of doses against this disease received prior to illness onset: 0-6 99=unk (doses)

Date of last dose against this disease prior to illness onset: ____ ____ ____ (mm/dd/yyyy)

Vaccine Type	Vaccination Date <small>month day year</small>	Vaccine Manuf	Vaccine Lot Number	Vaccine Expiry Date <small>month day year</small>	National Drug Code	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

VACCINE TYPE CODES

W=DTP whole cell X=Tdap
 A=DTaP unspecified K=DTaP-IPV
 R=DTaP 5 pertussis V=DTaP-IPV-HepB
 H=DTap-Hib N=DTaP-IPV-Hib
 D=DT or Td H=DTaP-IPV-HIB-HEPB historical
 T=DTP-Hib B=DTaP,IPV,Hib,HepB
 P=pertussis only O=other (specify)

VACCINE MANUFACTURER CODES

C = Sanofi Pasteur
 L=Wyeth
 S=GlaxoSmithKline
 M=Massachusetts Health Department
 I=Michigan Health Department
 N=North American Vaccine
 O = other (specify)
 U = unknown

VACCINE EVENT INFORMATION SOURCE CODES

00= new immunization record
 01= historical information, source unidentified
 02= historical information, other provider
 05= historical information, other registry
 06= historical information, birth certificate OTH= other
 07= historical information, school record UNK= unknown
 08= historical information, public agency
 09= historical information, patient or parent recall
 10= historical information, patient or parent written record

Reason not Vaccinated per ACIP

1 = religious exemption 5 = MD diagnosis of previous disease 9 = unknown 13 = parent/patient unaware of recommendation
 2 = medical contraindication 6 = too young 10 = parent/patient forgot to vaccinate 14 = missed opportunity
 3 = philosophical objection 7 = parent/patient refusal 11 = vaccine record incomplete/unavailable 15 = foreign visitor
 4 = lab evidence of previous disease 8 = other _____ 12 = parent/patient report of previous disease 16 = immigrant

EXPOSURE

Epi-linked to confirmed case? Y=yes N=no U=Unknown **Outbreak related?** Y=yes N=no U=unknown **Outbreak Name** _____

Country of Exposure _____ **State/Province of Exposure** _____ **County of Exposure** _____ **City of Exposure** _____

IMPORTATION

Imported Code 1=Indigenous 2=international 3=in state, out of jurisdiction 4=out of state 5=imported, unable to determine source 9=unknown

Imported Country _____ **Imported State** _____ **Imported County** _____ **Imported City** _____

TRANSMISSION SETTING

1 = day care 2 = school 3 = doctor's office 4 = hospital ward 5 = hospital ER
 6 = hospital outpatient 7 = home 8 = other _____ 9 = unknown
 10 = college 11 = military 12 = correctional facility 13 = place of worship
 14 = international travel 15 = community 16 = work 17 = athletics

Transmission Mode

EPIDEMIOLOGIC INFORMATION

Mother's age at infant's birth (if case <1yr old) **Did mother receive Tdap (if case <1yr old)?** Y=yes N=no U=unknown

When was Tdap administered? prior to pregnancy during pregnancy postpartum other _____ unknown

Date Tdap Administered _____ month day year **Gestational Age (if case <1yr old)** weeks **Infant Birth Weight (if case <1 yr old)** **Birth Weight Units**
 gram pound
 kilogram ounce

Was case-patient a healthcare provider at onset of illness? Y=yes N=no U=unknown

Transmission Setting of Further Spread
 1 = day care 2 = school 3 = doctor's office 4 = hospital ward 5 = hospital ER 6 = hospital outpatient clinic 7 = home
 8 = other _____ 9 = unknown 10 = college 11 = military 12 = correctional facility 13 = church
 14 = international travel 15 = work 16 = athletics 17 = community 18 = no documented spread outside 19 = setting outside household

One or more suspected sources of infection? Y=yes N=no U=unknown **Number of Suspected Sources**

Suspected Source	Age	Age Unit [†]	Sex	Relationship to Case	Cough Onset Date month day year	Number of Contacts Recommended Prophylaxis <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Relationship Codes	
							bro=brother	ngh=neighbor
Source 1	---	-----	---	-----	-----		fth=father	oth=other (specify)
Source 2	---	-----	---	-----	-----		fnf=friend	sis=sister
Source 3	---	-----	---	-----	-----		grp=grandparent	spo=spouse
							mth=mother	unk=unknown
							Sex Codes F=female M=male U=unk	

[†]Units a=year d=day mo=month wk=week unk=unknown

CASE NOTIFICATION

Condition Code **10190** **Immediate National Notifiable Condition** Y=yes N=no U=unknown **Legacy Case ID** _____

State Case ID _____ **Local Record ID** _____ **Jurisdiction Code** ____ **Binational Reporting Criteria** _____

Date First Verbal Notification to CDC _____ month day year **Date First Electronically Submitted** _____ month day year

Date of Electronic Case Notification to CDC _____ month day year **MMWR Week** _____ **MMWR Year** _____

Current Occupation (type of work case-patient does) _____ **Current Occupation Standardized (NIOCCS code)** _____

Current Industry (type of business or industry in which case-patient works) _____ **Current Industry Standardized (NIOCCS code)** _____

Person Reporting to CDC NAME _____ (first) _____ (last) **Person Reporting to CDC Email** _____ @ _____ **Person Reporting to CDC Phone Number** (____) _____

COMMENTS

CLINICAL CASE DEFINITION[†]

PROBABLE

- In the absence of a more likely diagnosis, illness meeting the clinical criteria

OR

- Illness with cough of any duration, with
 - At least one of the following signs or symptoms:
 - Paroxysms of coughing; or
 - inspiratory whoop; or
 - Post-tussive vomiting, or
 - Apnea (with or without cyanosis)

AND

- Contact with a laboratory confirmed case (epidemiological linkage)

CONFIRMED

Acute cough illness of any duration, with

- Isolation of *B. pertussis* from a clinical specimen **OR**
- PCR positive for *B. pertussis*

[†]<https://wwwn.cdc.gov/nndss/conditions/pertussis/case-definition/2020/>