PERTUSSIS REPORTING FORM - MINNESOTA DEPARTMENT OF HEALTH

Onset date:____/____/____ **Report date:**____/____/____

DEMOGRAPHIC INFORMATION

Name

Last: **First:** **MI:**

DOB:____/____/____ Age:_____ ☐Days ☐Months ☐Years

Gender: ☐Male ☐Female ☐Transgender ☐Unknown

Medical record #: _____

Preferred language: ☐English ☐Other:_____

Country of birth: ☐U.S. ☐Other:_____ ☐Unknown

Address:_____

☐Unknown ☐Homeless

City:_____ **State**:____ **Zip**:_____

County:_____

Phone 1st:_____ **Phone 2nd**:_____

Occupation:_____ **Parent/Guardian:**_____

Ethnicity:

☐Hispanic/Latino

☐Non-Hispanic/ Non-Latino

☐Unknown

Race (check all that apply):

☐American Indian/Alaskan Native ☐Asian

☐Black/African American ☐White

☐Native Hawaiian/Pacific Islander ☐Unknown

☐Other:_____

LABORATORY AND FACILITY INFORMATION

Reporter:

Name: **Phone**:

Institution/Clinic: _____

City: _____

Ordering provider:_____ **Ph**:_____

Primary care provider: _____ **Ph**:_____

Lab Name:_____ **Ph**:_____

MDH contact if additional information needed (choose at least one):

☐Reporter ☐Primary care provider ☐Ordering provider ☐Lab

☐Other:_____

Was the patient hospitalized? ☐Yes ☐No ☐Unknown

Hospital name: _____

Admit date: ____/____/____ **Discharge date:** ____/____/____

Died? ☐Yes ☐No ☐Unknown **If yes, date of death**: ____/____/____

Specimen collection date: _____/_____/_____

Specimen source :_____

Pregnant (if applicable): ☐Yes ☐No ☐Unknown

If yes, due date: _____/_____/_____

PERTUSSIS SPECIFIC INFORMATION

Attend school or work: ☐ Yes ☐ No ☐ Unknown **If yes, school name and/or work location**:_____

Childcare attendee/worker: ☐ Yes ☐ No ☐ Unknown **If yes, childcare center name**:_____

Did the patient have:

Cough ☐ Yes ☐ No ☐ Unknown **If yes, cough onset date:** ____/____/____

Paroxysmal cough ☐ Yes ☐ No ☐ Unknown **Whoop** ☐ Yes ☐ No ☐ Unknown

Apnea ☐ Yes ☐ No ☐ Unknown **Post-tussive vomiting** ☐ Yes ☐ No ☐ Unknown

Acute encephalophathy ☐ Yes ☐ No ☐ Unknown **Seizures** ☐ Yes ☐ No ☐ Unknown

Diagnosed with pneumonia ☐ Yes ☐ No ☐ Unknown

Xray for pneumonia ☐ Yes ☐ No ☐ Unknown **If yes, xray findings** ☐ Positive ☐ Negative ☐ Not Done ☐ Unknown

Antibiotics prescribed: ☐ Yes ☐ No ☐ Unknown

1st Antibiotic: ☐ Erythromycin ☐ Clarithomycin/azithromycin ☐ Tetracycline/doxycycline ☐ Other: _____ ☐ Unknown
Date started: ____/____/____ No. days prescribed: _____ Actual no. of days taken: _____

2nd Antibiotic: ☐ Erythromycin ☐ Clarithomycin/azithromycin ☐ Tetracycline/doxycycline ☐ Other: _____ ☐ Unknown
Date started: ____/____/____ No. days prescribed: _____ Actual no. of days taken: _____

3rd Antibiotic: ☐ Erythromycin ☐ Clarithomycin/azithromycin ☐ Tetracycline/doxycycline ☐ Other: _____ ☐ Unknown
Date started: ____/____/____ No. days prescribed: _____ Actual no. of days taken: _____

Did the patient have any of the following underlying conditions prior to illness (check all that apply):

☐ Asthma ☐ Cystic fibrosis ☐ HIV/AIDS ☐ Other respiratory illness, specify _____

☐ Other, specify _____

LABORATORY INFORMATION

Was laboratory testing for pertussis done? ☐ Yes ☐ No ☐ Unknown

Culture Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Parapertussis ☐ Unknown ☐ Other
Date specimen collected: _____/_____/_____ **Laboratory name:** _____

PCR Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Parapertussis ☐ Unknown ☐ Other
Date specimen collected: _____/_____/_____ **Laboratory name:** _____

DFA Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Parapertussis ☐ Unknown ☐ Other
Date specimen collected: _____/_____/_____ **Laboratory name:** _____

Serology (acute) Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Parapertussis ☐ Unknown ☐ Other
Date acute specimen collected: _____/_____/_____ **Laboratory name:** _____

VACCINE HISTORY

Has the patient ever received any doses of diphtheria (D), tetanus (T), and/or pertussis (P)-containing vaccine? ☐ Yes ☐ No ☐ Unknown
If yes, date of last pertussis-containing vaccine prior to illness: _____/_____/_____

Please indicate the reason if the patient has not received 3 or more pertussis-containing vaccines:
☐ Religious exemption ☐ Medical contrindication ☐ Philosophical exemption ☐ Previous culture/MD confirmed pertussis
☐ Parental refusal ☐ Age < 7 months ☐ Other ☐ Unknown

Please complete for pertussis-containing vaccines:

Vaccination Date	Vaccine Type	Vaccine Manufacturer	Lot Number
1. _____/_____/_____	☐ DTP whole cell ☐ DtaP or Dtap-Hib ☐ DT/ Td ☐ DTP-Hib Tetramune ☐ Tdap ☐ Pertussis only ☐ Other ☐ Unknown	☐ Aventis ☐ Connaught ☐ GlaxoSmithKline ☐ Lederle ☐ Sanofi Pasteur ☐ Wyeth ☐MA Dept of Health ☐ MI Dept of Health ☐ North American Vaccine ☐ Unknown	_____
2. _____/_____/_____	☐ DTP whole cell ☐ DtaP or Dtap-Hib ☐ DT/ Td ☐ DTP-Hib Tetramune ☐ Tdap ☐ Pertussis only ☐ Other ☐ Unknown	☐ Aventis ☐ Connaught ☐ GlaxoSmithKline ☐ Lederle ☐ Sanofi Pasteur ☐ Wyeth ☐MA Dept of Health ☐ MI Dept of Health ☐ North American Vaccine ☐ Unknown	_____
3. _____/_____/_____	☐ DTP whole cell ☐ DtaP or Dtap-Hib ☐ DT/ Td ☐ DTP-Hib Tetramune ☐ Tdap ☐ Pertussis only ☐ Other ☐ Unknown	☐ Aventis ☐ Connaught ☐ GlaxoSmithKline ☐ Lederle ☐ Sanofi Pasteur ☐ Wyeth ☐MA Dept of Health ☐ MI Dept of Health ☐ North American Vaccine ☐ Unknown	_____
4. _____/_____/_____	☐ DTP whole cell ☐ DtaP or Dtap-Hib ☐ DT/ Td ☐ DTP-Hib Tetramune ☐ Tdap ☐ Pertussis only ☐ Other ☐ Unknown	☐ Aventis ☐ Connaught ☐ GlaxoSmithKline ☐ Lederle ☐ Sanofi Pasteur ☐ Wyeth ☐MA Dept of Health ☐ MI Dept of Health ☐ North American Vaccine ☐ Unknown	_____
5. _____/_____/_____	☐ DTP whole cell ☐ DtaP or Dtap-Hib ☐ DT/ Td ☐ DTP-Hib Tetramune ☐ Tdap ☐ Pertussis only ☐ Other ☐ Unknown	☐ Aventis ☐ Connaught ☐ GlaxoSmithKline ☐ Lederle ☐ Sanofi Pasteur ☐ Wyeth ☐MA Dept of Health ☐ MI Dept of Health ☐ North American Vaccine ☐ Unknown	_____
6. _____/_____/_____	☐ DTP whole cell ☐ DtaP or Dtap-Hib ☐ DT/ Td ☐ DTP-Hib Tetramune ☐ Tdap ☐ Pertussis only ☐ Other ☐ Unknown	☐ Aventis ☐ Connaught ☐ GlaxoSmithKline ☐ Lederle ☐ Sanofi Pasteur ☐ Wyeth ☐MA Dept of Health ☐ MI Dept of Health ☐ North American Vaccine ☐ Unknown	_____

EPIDEMIOLOGIC INFORMATION

Is the source of the infection known? ☐ Yes ☐ No ☐ Unknown

If known, source's relationship to the patient: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Neighbor ☐ Daycare ☐ Grand parent ☐ Friend ☐ Other relative ☐ Babysitter (non-daycare) ☐ Other ☐ Unknown

Source's sex: ☐ Male ☐ Female ☐ Unknown **Source's age**: _____ ☐ Years ☐ Weeks ☐ Months ☐ Days

If known, where did the patient acquire pertussis? _____

Is the patient related to an outbreak of pertussis? ☐ Yes ☐ No ☐ Unknown

If yes, identify outbreak (e.g., school, daycare name): _____