North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

PERTUSSIS (WHOOPING COUGH)
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 47

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

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

	Date Specimen Collected (month/day/year)	Result	Is case laboratory-confirmed? ☐ Yes ☐ No
Culture	/ /		Result Code P Positive N Negative I Indeterminate E Pending X Not Done S Parapertussis
DFA	/ /		
PCR	/ /		
Serology (1st specimen)	/ /		
Serology (2nd specimen)	/ /		

Note: Serology is based on either single sample or combined result from acute and convalescent samples.

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Encephalopathy ☐ Y ☐ N ☐ U
Seizures/convulsions ☐ Y ☐ N ☐ U
If yes, specify
☐ New onset
☐ Exacerbation of underlying seizure disorder
☐ Other, specify:_____
☐ Unknown
Cough ☐ Y ☐ N ☐ U
Onset date (mm/dd/yyyy):____/____/____
Was patient still coughing at final interview? ☐ Y ☐ N ☐ U
Final interview date (mm/dd/yyyy):____/____/____
(at least two weeks after cough onset)
Duration of cough at final interview: _____ days
This must be at least 14 days of cough.
Paroxysmal cough ☐ Y ☐ N ☐ U
Whoop ☐ Y ☐ N ☐ U
Post-tussive vomiting ☐ Y ☐ N ☐ U
Apnea ☐ Y ☐ N ☐ U
Chest x-ray ☐ Y ☐ N ☐ U
If yes, Chest x-ray abnormal? ☐ Y ☐ N ☐ U
Pneumonia ☐ Y ☐ N ☐ U
If yes, confirmed by x-ray or CT ☐ Y ☐ N ☐ U
Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐ Y ☐ N ☐ U
If yes, specify: _____

TREATMENT
Did patient take an antibiotic as treatment for this illness? ☐ Y ☐ N ☐ U
If yes, specify antibiotic name:_____
Dose _____
Date antibiotic began____/____/____
Date antibiotic ended____/____/____
Were antibiotics taken before culture specimen collected? ☐ Y ☐ N ☐ U
Specify culture site(s):_____
Was antibiotic prophylaxis given prior to illness onset? ☐ Y ☐ N ☐ U
Did the patient require mechanical ventilation? ☐ Y ☐ N ☐ U
Date started (mm/dd/yyyy):____/____/____
Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____
Restrictions to movement or freedom of action? ☐ Y ☐ N
Check all that apply:
☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify
_____

Date control measures issued:____/____/____
Date control measures ended:____/____/____
Was patient compliant with control measures? ☐ Y ☐ N
Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U
If yes, list person(s) and contact information:

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U
If yes, specify name and relationship to person(s)

Is the patient part of an outbreak of this disease? ☐ Y ☐ N
VACCINE
Has patient ever received pertussis-containing vaccine? ☐ Y ☐ N ☐ U
Vaccine #1:
Date of vaccination (mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer: _____
Product/trade name: _____
Lot number:_____
Vaccine #2:
Date of vaccination (mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer: _____
Product/trade name: _____

(CONTINUED)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
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NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE (CONTINUED)

Lot number:_____
Vaccine #3:
Date of vaccination (mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer: _____
Product/trade name: _____
Lot number:_____
Vaccine #4:
Date of vaccination (mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer: _____
Product/trade name: _____
Lot number:_____
Vaccine #5:
Date of vaccination (mm/dd/yyyy):____/____/____
Vaccine type:_____
Manufacturer: _____
Product/trade name: _____
Lot number:_____

Vaccine date unknown ☐ Y ☐ N

Reason for inadequate vaccination:
- ☐ Religious exemption
- ☐ Medical exemption
- ☐ Medical contraindication
- ☐ Philosophical exemption (outside NC only)
- ☐ Laboratory evidence of previous disease
- ☐ Physician diagnosis of previous disease
- ☐ Under age for vaccination
- ☐ Parental refusal
- ☐ Missed opportunities
- ☐ Unknown
- ☐ Other, specify:_____

Source of vaccine information:
- ☐ Patient's or Parent's verbal report
- ☐ Physician
- ☐ Medical record *(Note: Any vaccine on a medical record should be recorded in the NCIR)*
- ☐ Certificate of immunization record *(Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)*
- ☐ Patient vaccine record
- ☐ School record
- ☐ Other, specify:_____
- ☐ NCIR record
- ☐ Unknown

Number of doses received prior to illness:_____

Date of last pertussis containing vaccine prior to onset of this illness: (mm/dd/yyyy):____/____/____

REASON FOR TESTING

Why was the patient tested for this condition?
- ☐ Symptomatic of disease
- ☐ Screening of asymptomatic person with reported risk factor(s)
- ☐ Exposed to organism causing this disease (asymptomatic)
- ☐ Household / close contact to a person reported with this disease
- ☐ Other, specify_____
- ☐ Unknown

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____
_____

Survived? ☐ Y ☐ N ☐ U
Died? ☐ Y ☐ N ☐ U
If yes:
Died from this illness? ☐ Y ☐ N ☐ U
If yes, location of death:
Patient died in North Carolina? ☐ Y ☐ N ☐ U
County of death:_____
Died outside NC? ☐ Y ☐ N ☐ U
Specify where:_____
Autopsy performed? ☐ Y ☐ N ☐ U
Facility where autopsy was performed:
_____
Patient autopsied in NC? ☐ Y ☐ N ☐ U
County of autopsy:_____
☐ Autopsied outside NC, specify where:_____

Source of death information (select all that apply):
Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.
- ☐ Death certificate
- ☐ Autopsy report final conclusions
- ☐ Hospital/physician discharge summary
- ☐ Other:_____

Cause of death:_____
Death date (mm/dd/yyyy):____/____/____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U
Specify _____
_____

Other underlying illness ☐ Y ☐ N ☐ U
Please specify: _____

Was the patient receiving any of the following treatments or taking any medications?
Antibiotics ☐ Y ☐ N ☐ U
For what medical condition?
_____
Chemotherapy ☐ Y ☐ N ☐ U
If yes, was therapy within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition?
_____
Radiotherapy ☐ Y ☐ N ☐ U
If yes, was therapy within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition?
_____
Systemic steroids/corticosteroids, including steroids taken by mouth or injection ☐ Y ☐ N ☐ U
If yes, was medication taken within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition?
_____
Immunosuppresive therapy, including anti-rejection therapy ☐ Y ☐ N ☐ U
If yes, specify: _____
If yes, was medication taken within the last 30 days before this illness? ☐ Y ☐ N ☐ U
For what medical condition?
_____
Aspirin or aspirin-containing product ☐ Y ☐ N ☐ U
For what medical condition?
_____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did **local health director or designee implement additional control measures?** (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐ Y ☐ N
If yes, specify: _____
_____

Were written isolation orders issued? ☐ Y ☐ N
If yes, where was the patient isolated? _____
_____
Date isolation started?____/____/____
Date isolation ended?____/____/____
Was the patient compliant with isolation? ☐ Y ☐ N

Were written quarantine orders issued? ☐ Y ☐ N
If yes, where was the patient quarantined?
_____
Date quarantine started?____/____/____
Date quarantine ended?____/____/____
Was the patient compliant with quarantine? ☐ Y ☐ N

Notes:

MATERNAL INFORMATION

At the time of birth, was the mother immune suppressed or did she have a chronic underlying medical condition? ☐ Y ☐ N ☐ U
If yes, specify: _____
_____

INFANT BIRTH DETAILS

Hospital or facility where infant was born
_____
Infant gestational age at birth _____
☐ Full Term ☐ Premature ☐ Unknown
Number of weeks gestation _____
Birth Weight _____
Unit:
- ☐ Pounds/ounces
- ☐ Grams
- ☐ Birth weight unknown

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TRAVEL/IMMIGRATION

The patient is:

- ☐ Resident North Carolina
- ☐ Resident of another state or US territory
- ☐ Foreign visitor
- ☐ Refugee
  - Refugee camp(s)? ..... ☐ Y ☐ N ☐ U
  - Name of camp_____
  - Location of camp_____
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US____/____/____
- ☐ Recent immigrant
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US____/____/____
- ☐ Foreign adoptee
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US____/____/____
- ☐ None of the above

Did patient have a travel history during the 21 days prior to onset of symptoms until 5 days after start of antibiotics? ..... ☐ Y ☐ N ☐ U

Travel dates:

From:____/____/____ until ____/____/____

To city:_____State: _____

To country:_____

Reason(s) for travel:

- ☐ Vacation / tourism
- ☐ Organized tour
- ☐ Business related, specify _____
- ☐ Military related
- ☐ Visit to family / friends
- ☐ Peace corps
- ☐ Airline / Ship crew
- ☐ Missionary or dependent
- ☐ Refugee / Immigrant
- ☐ Student / Teacher
- ☐ Unknown
- ☐ Other_____

Mode(s) of transportation (check all that apply)

- ☐ Airplane
- ☐ Ship / boat / ferry
  - Cruise ship? ..... ☐ Y ☐ N ☐ U
  - Specify cruise line _____
- ☐ Train / subway
- ☐ On foot
- ☐ Bus/taxi/shuttle
- ☐ Automobile / motorcycle
- ☐ Other, specify:_____

Notes on travel/residency:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 21 days prior to onset of symptoms until 5 days after start of antibiotics did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ..... ☐ Y ☐ N ☐ U

Name of facility:_____

Dates of contact: from ___/___/___ until ___/___/___

During the 21 days prior to onset of symptoms until 5 days after start of antibiotics, did the patient attend social gatherings or crowded settings? ..... ☐ Y ☐ N ☐ U

If yes, specify:_____

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) _____
- ☐ Unknown

Does the patient have any other risk factors for this disease? ..... ☐ Y ☐ N ☐ U

Specify: _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ..... ☐ Y ☐ N ☐ U

- Name of care provider: _____
- Address: _____
- City:_____State: _____
- Zip code:_____County:_____
- Contact name:_____
- Telephone: (_____) _____

Patient a child care worker or volunteer in child care? ..... ☐ Y ☐ N ☐ U

- Name of child care provider: _____
- Address: _____
- City:_____State: _____
- Zip code:_____County:_____
- Contact name:_____
- Telephone: (_____) _____

Patient a parent or primary caregiver of a child in child care? ..... ☐ Y ☐ N ☐ U

- Name of child care provider: _____
- Address: _____
- City:_____State: _____
- Zip code:_____County:_____
- Contact name:_____
- Telephone: (_____) _____

Is patient a student? ..... ☐ Y ☐ N ☐ U

Type of school:

- ☐ NC Public School (preK-12)
- ☐ NC Private School (preK-12)
- ☐ Other School (preK-12)
- ☐ Community College/College/University
- ☐ Other academic institution (i.e. trade school, professional school, etc)
  - Name: _____
  - Address: _____
  - City:_____State: _____
  - Zip code:_____County:_____
  - Contact name:_____
  - Telephone: (_____)_____
  - Specify grade:_____

Is patient a school WORKER / VOLUNTEER in NC school setting? ..... ☐ Y ☐ N ☐ U

Type of school

- ☐ NC Public School (preK-12)
- ☐ NC Private School (preK-12)
- ☐ Other School (preK-12)
- ☐ Community College/College/University
- ☐ Other academic institution (i.e. trade school, professional school, etc)
  - Name: _____
  - Address: _____
  - City:_____State: _____
  - Zip code:_____County:_____
  - Telephone: (_____)_____

Notes:

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HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISK

During the 21 days prior to onset of symptoms until 5 days after start of antibiotics, did the patient have any of the following health care exposures?

Emergency Dept. (not hospitalized)... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):____/____/____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

Hospital ..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):____/____/____
- Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

LTC facility—resident..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):____/____/____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):____/____/____
- Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

Outpatient facility—patient..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):____/____/____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

Visitor to health care setting ..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):____/____/____
- Until date (mm/dd/yyyy):____/____/____
- Frequency:
  ☐ Once
  ☐ Multiple times within this time period
  ☐ Daily
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

Worked or volunteered in health care or clinical setting ..... ☐ Y ☐ N ☐ U
- Facility name_____
- City_____State _____
- Country _____
- Occupation:
  ☐ Physician
  ☐ Physician's assistant or nurse practitioner
  ☐ Nurse
  ☐ Laboratory
  ☐ Other, specify_____
  ☐ Unknown
- Specify work setting or volunteer duties:
- Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy):____/____/____

Other, specify_____

Was patient employed in a laboratory? ..... ☐ Y ☐ N ☐ U
- If yes, specify and give details: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U
- Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ..... ☐ Y ☐ N ☐ U
- Who was interviewed?

Were health care providers consulted? ..... ☐ Y ☐ N ☐ U
- Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
- City _____
- County_____

☐ Outside NC, but within US
- City _____
- State _____
- County_____

☐ Outside US
- City _____
- Country _____

☐ Unknown

Notes: