

NAME (Last, First)			Hospital Record No.		
Address (Street and No.)		City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/Lab		Address			Phone

-----DETACH HERE and transmit only lower portion if sent to CDC-----

Pertussis Surveillance Worksheet

CDC NETSS id		County		State		Zip	
Birth Date Month Day Year		Age Unk = 999		Age Type 0 = 0-120 years 3 = 0-28 days 1 = 0-11 months 9 = Age unknown 2 = 0-52 weeks		Race N = Native Amer./Alaskan Native W = White A = Asian/Pacific Islander O = Other B = African American U = Unknown	
Event Date Month Day Year		Event Type 1 = Onset Date 4 = Reported to County 2 = Diagnosis Date 5 = Reported to State of 3 = Lab Test Done 6 = Unknown MMWR Report Date		Outbreak Associated Unk = 999		Reported Month Day Year	
				Imported 1 = Indigenous 2 = International 3 = Out of State 9 = Unknown		Report Status 1 = Confirmed 2 = Probable 3 = Suspect 9 = Unknown	

CLINICAL DATA	Any Cough? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Cough Onset Month Day Year		Paroxysmal Cough? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Whoop? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Chest X-ray for Pneumonia <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown		Seizures Due to Pertussis <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	
	Posttussive Vomiting? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Apnea? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Final Interview Date Month Day Year				Acute Encephalopathy Due to Pertussis <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown			
	Cough at Final Interview? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Duration of Cough at Final Interview Days				Hospitalized? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Days Hospitalized 0 - 998 999 - Unknown		Died? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	

TREATMENT	Were Antibiotics Given? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		First Antibiotic Received 1 = Erythromycin (incl. pediazole, ilosone) 6 = Other 2 = Cotrimoxazole (bactrim/septria) 9 = Unknown 3 = Clarithromycin/azithromycin 4 = Tetracycline/Doxycycline 5 = Amoxicillin/Penicillin/ Ampicillin/Augmentin/Ceclor/Cefixime		Was Laboratory Testing for Pertussis Done? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Result		Date Specimen Taken Month Day Year			
	Date Started First Antibiotic Month Day Year		Days First Antibiotic Actually Taken 0 - 98 99 - Unknown		Culture <input type="checkbox"/>		DFA <input type="checkbox"/>		Serology 1 <input type="checkbox"/>		Serology 2 <input type="checkbox"/>	
	Second Antibiotic Received <input type="checkbox"/> See Choices for First Antibiotic Given		Date Started Second Antibiotic Month Day Year		Days Second Antibiotic Actually Taken 0 - 98 99 - Unknown		PCR <input type="checkbox"/>					

VACCINE HISTORY	Vaccinated? (Received any doses of diphtheria, tetanus, and/or pertussis -containing vaccines) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Date First Reported to a Health Department Month Day Year		Date Case Investigation Started Month Day Year	
	Vaccination Date Month Day Year		Vaccine Type*		Vaccine Manuf.*	
	Lot Number*		Outbreak Related? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Epi-Linked? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	
	Reason Not Vaccinated With ≥ 3 Doses of Pertussis Vaccine 1 = Religious Exemption 5 = Parental Refusal 2 = Medical Contraindication 6 = Age Less Than 7 Months 3 = Philosophical Exemption 7 = Other 4 = Previous Pertussis Confirmed by Culture or MD 9 = Unknown		Outbreak Name (Name of outbreak this case is associated with)		Transmission Setting (Where did this case acquire pertussis?) 1 = Day Care 6 = Hosp. Outpatient Clinic 11 = Military 2 = School 7 = Home 12 = Correctional Facility 3 = Doctor's Office 8 = Work 13 = Church 4 = Hospital Ward 9 = Unknown 14 = International Travel 5 = Hospital ER 10 = College 15 = Other	
	Date of Last Pertussis-Containing Vaccine Prior to Illness Onset Month Day Year		Number of Doses of Pertussis-Containing Vaccine Prior to Illness Onset 0 - 6 9 = Unknown		Setting (Outside Household) of Further Documented Spread From This Case <input type="checkbox"/> Use same codes as for Transmission Settings, except: 7 = >1 Setting Outside Household 16 = No Documented Spread Outside Household	

