CDC • National Center for Immunization and Respiratory Diseases

PERTUSSIS DEATH WORKSHEET

NEDSS ID: ☐☐☐☐☐☐☐☐☐☐

STATE ID: ☐☐☐☐☐☐☐☐☐☐

Patient's Initials ☐☐☐

Date of Birth ☐☐☐

Date of Cough Onset ☐☐☐

Date of Death ☐☐☐

Sex: ☐ Male ☐ Female

Race*: _____ Ethnicity*: _____

Reporting State*: _____

Report Completed By*: _____

Telephone Number: _____

Where did the patient die? ☐ Home ☐ Hospital ☐ En route to hospital ☐ Other (specify)

Was an autopsy performed? ☐ Yes ☐ No ☐ Unknown

CHECKLIST OF DOCUMENTS TO BE SENT TO CDC

Send to: **The Pertussis Surveillance Coordinator, MS E61, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention, 1600 Clifton Road NE, Atlanta Ga 30333 Fax# 404-639-8616**

No.	Document**	Yes / No
1	Pertussis case investigation form	
2	Copy of all patient's vaccination records	
3	Admission history and physical	
4	Discharge summary	
5	All medical records, including Emergency Dept notes and lab results***	
6	Death certificate	
7	Autopsy report	

PATIENT'S VACCINATION INFORMATION

Dose	Vaccine Type*	Date Administered	Manufacturer	Lot Number	Data Source ‡
First					
Second					
Third					
Fourth					
Fifth					
Booster 1					
Booster 2					

* *Please use the same codes as in the Pertussis Case Report Worksheet*

** *Please obtain information from each hospital*

*** *Medical Chart/record also includes inpatient progress notes, x-ray reports, echocardiography reports, doctor's office notes, vaccination records, lab reports*

‡ *Data Source: Provider Record = 1; Parent Vaccination Card = 2; Other baby record (e.g.baby book) = 3; Parent's History (no record) = 4; Other source = 5 (please specify).*

DOCTOR'S OFFICE/CLINIC/EMERGENCY DEPARTMENT VISITS

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown

Please list the admission date(s) and discharge dates/transfer dates for this illness in chronological order.

Date of visit	Name and Address of Clinic, Doctor's office, or Emergency Department visited	Telephone Number

CLINICAL DATA

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown

Please list the admission date(s) and discharge dates/transfer dates for this illness in chronological order.

Hospital Name	Date of Admission	Date of Discharge or Transfer	Discharge Diagnosis

RESPIRATORY SUPPORT

	Yes/ No	Date Started
Supplemental O_2 without intubation (e.g. mask)		
Supplemental O_2 via endotracheal intubation		
Contunuous mechanical ventilation		
High Frequency Oscillatory Ventilation		
Extracorporeal Membrane Oxygenation		

LABORATORY STUDIES

Include tests obtained up to 30 days prior to onset

Specimen	Collection Date	Culture Result	PCR	DFA	ELISA
Nasopharyngeal - *B. pertussis*					
-RSV					
-Adenovirus					
-Influenza					
-Parainfluenza					
-Other (specify pathogen)					
-RSV					
Blood					
	Date	**Count**			
Total WBC Count (initial)			% Lymphocyte		
Highest WBC count			% Lymphocyte		

OTHER STUDIES

	Yes/ No	Date Performed	Result
Chest x-ray			
Echocardiography			

Was pulmonary hypertension a diagnosis in this patient? ☐ Yes ☐ No ☐ Unknown

Was the patient treated with antibiotics? ☐ Yes ☐ No ☐ Unknown

If Yes please list all the antibiotics and the dates when given

Antibiotic Treatment	Date Started	Date Ended

OTHER MEDICAL AND FAMILY INFORMATION

What is the birth mother's date of birth? ☐☐☐ If unknown, what is the birth mother's age? _____

At the time of the patient's birth, did the mother have an immune supressed or a chronic underlying medical condition? ☐ Yes ☐ No ☐ Unknown

If Yes, what is the name of the condition? _____

If the patient was <1 year old, what was the gestational age of the infant at the time of delivery? _____ weeks

What was the weight of the infant at birth? _____ lb _____ oz ***or*** _____ kg _____ gm

Did the patient have underlying or previous medical conditions? ☐ Yes ☐ No ☐ Unknown

If Yes, please give details _____

In the table below, list everyone who lives in the household, their date of birth, age, sex, the number of doses of pertussis-containing vaccine received and date of the last pertussis vaccine dose, smoking habits at home and the presence of a cough illness during the 3-week period prior to the cough onset date in the patient. Please indicate if pertussis was the diagnosis for the cough illness, an if so, how prertussis was confirmed.

No.	Relationship to patient	Date of birth	Age	Sex	Doses of DTP/DTaP/ Tdap/P vaccine	Date of last dose	Smoking habits at home		Cough illness in family member during 3-week period prior to cough onset date in case patient			
							Current smoker? (Yes/No)	Avg. no. of cigarettes smoked daily	Cough (Yes/No)	Cough onset date	Pertussis diagnosis? (Yes/No)	Confirmation method (Culture/ PCR/ DFA/ Serology/ None)
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

During the 3-week period prior to the cough onset, was the patient exposed to anyone outside the household who was known to have a cough illness ☐ Yes ☐ No ☐ Unknown

If Yes, List all persons who had a cough illness and who may have exposed the patient, with the dates of cough onset in the table below.

No.	Relationship to patient	Date of birth	Age	Sex	No. doses of DTP/DTaP/ Tdap/DT vaccine*	Date of last dose	Cough onset date	Date cough stopped	Pertussis diagnosis	Confirmation method (Culture/ PCR/ DFA/ Serology/ None)
1										
2										
3										
4										
5										

* *Indicate type of vaccine if available*