Kansas Pertussis (Whooping Cough) Reporting Form

Kansas Department of Health and Environment

Today's Date: ____ /____ /____

Name of person reporting: _____ **Facility:** _____ **Phone:** _____

Patient's Name (Last, First, Middle): _____

Phone: _____ **Address:** _____

City: _____ **Zip:** _____ **County:** _____

Date of Birth: ____ /____ /____

Race: (Check all that apply)
☐ White
☐ Black
☐ Asian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander

Ethnicity:
☐Hispanic or Latino
☐Not Hispanic or Latino

Sex:
☐Male
☐Female

Pregnant:
☐Yes
☐No

Hospitalized:
☐Yes
☐No
If yes, **date hospitalized:** ____ /____ /____

If yes, **hospital name:** _____

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

Clinical Symptoms

Cough Onset Date: ____ /____ /____ Cough duration: **____days**

Paroxysmal cough? ☐ Yes ☐ No ☐ Unknown Date paroxysms started? ____ /____ /____
Inspiratory whoop? ☐ Yes ☐ No ☐ Unknown Post-tussive emesis? ☐ Yes ☐ No ☐ Unknown
Apnea (infants)? ☐ Yes ☐ No ☐ Unknown Cyanosis? ☐ Yes ☐ No ☐ Unknown

Has the patient/guardian been notified of pertussis? ☐Yes ☐No

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Laboratory Information:

Specimen Collection Date: ____ /____ /____ Date Result Reported to Physician: ____ /____ /____

Name of test performed: _____ Results of Test: _____

Name of Laboratory: _____ Laboratory Results attached? ☐ Yes ☐ No

☐ **Specimen not collected or tested**

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Attends/teaches school or daycare? ☐ Yes ☐ No ☐ Unknown

If yes, **facility name and grade**:_____

Has previously received pertussis vaccine? ☐ Yes ☐ No ☐ Unknown

If yes, please circle type and enter dates of all pertussis-containing vaccines:

DTP/DTaP/Tdap___/___/___ DTP/DTaP/Tdap ___/___/___ DTP/DTaP/Tdap ___/___/___

DTP/DTaP/Tdap___/___/___ DTP/DTaP/Tdap ___/___/___ DTP/DTaP/Tdap ___/___/___

If unimmunized, why?

☐Religious exemption ☐Medical contraindication ☐Previous disease
☐Parental refusal ☐Age <2 months ☐Unknown

Antibiotic treatment? ☐ Yes ☐ No

Date prescribed? ____ /____ /____

Antibiotic name: _____ Duration: _____

Does the case have contact with any high risk* persons? ☐ Yes ☐ No ☐ Unknown

***High-risk close contacts** of a pertussis case are defined as:*

- ***Infants <1 year old***
- ***Pregnant women** in the 3rd trimester of pregnancy*
- *All persons with **pre-existing health conditions** that may be exacerbated by a pertussis infection (for example, but not limited to immunocompromised persons and patients with moderate to severe medically treated asthma).*
- ***Contacts who themselves have close contact** with either infants under 12 months, pregnant women or individuals with pre-existing health conditions at risk of severe illness or complications.*

*All **contacts in high risk settings** that include infants aged <12 months or women in the third trimester of pregnancy.*

Was chemoprophylaxis given to household contacts and **high-risk*** close contacts? ☐ Yes ☐ No

If yes, please list names/relationship: _____

_____

_____

Physician Name: _____ **Physician Phone:** _____

Mail or fax reports to your local health department and/or to:

KDHE Bureau of Epidemiology and Public Health Informatics, 1000 SW Jackson, Suite 075, Topeka, KS 66612-1274

Fax: 877-427-7318 (toll-free) Epidemiology Hotline: **877-427-7317**