

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



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

PERTUSSIS (WHOOPIING 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.

Table with columns: Was laboratory testing for pertussis done?, Date Specimen Collected, Result, Is case laboratory-confirmed? Includes rows for Culture, DFA, PCR, Serology (1st and 2nd specimen).

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Main assessment section including: Is/was patient symptomatic for this disease?, TREATMENT (antibiotic, prophylaxis, hospitalization), Date control measures issued/ended, Does patient know anyone else with similar symptom(s) who had the same or similar travel history?, Does the patient know anyone else with similar symptoms?, Is the patient part of an outbreak of this disease?, VACCINE (has patient ever received pertussis-containing vaccine?, Vaccine #1 and #2 details).

(CONTINUED)

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

**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? \_\_\_\_\_

Immunosuppressive 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

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

**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  Airline / Ship crew  
 Organized tour  Missionary or dependent  
 Business related, specify \_\_\_\_\_  
 Military related  Refugee / Immigrant  
 Visit to family / friends  Student / Teacher  
 Peace corps  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?**

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

**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:**

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

**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:**

# **Pertussis (*Bordetella pertussis*) (Whooping Cough)**

## **1997 CDC Case Definition**

### **Clinical case definition**

A cough illness lasting at least 2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop," or post-tussive vomiting, without other apparent cause (as reported by a health professional)

### **Laboratory Criteria for Diagnosis**

- Isolation of *Bordetella pertussis* from clinical specimen
- Positive polymerase chain reaction (PCR) for *B. pertussis*

### **Case classification**

*Probable*: meets the clinical case definition, is not laboratory confirmed, and is not epidemiologically linked to a laboratory-confirmed case

*Confirmed*: a case that is culture positive and in which an acute cough illness of any duration is present; or a case that meets the clinical case definition and is confirmed by positive PCR; or a case that meets the clinical case definition and is epidemiologically linked directly to a case confirmed by either culture or PCR