Class I (b)
Report within 24hrs

CHICAGO DEPARTMENT OF PUBLIC HEALTH
PERTUSSIS CASE REPORT FORM (CRF)
FAX TO 312-746-6388

FINAL STATUS
❑ CONFIRMED ❑ SUSPECT
[CDPH USE ONLY]
❑ PROBABLE ❑ NOT A CASE

Date of Report:

Name of Person Reporting:

Reporting Facility:

Phone #: ( ) **Fax #: ( )**

PATIENT INFORMATION

Patient Name: **Parent/Guardian Name:**

Street Address: **Phone #: ( )**

City: **State:** **Zip:** **Insurance Status:** ❑Uninsured ❑Private ❑Public _____

Sex: ❑ Male ❑ Female **Age:** _____ ❑ **Years** ❑ **Months** ❑ **Weeks** ❑ **Days** **DOB: / /**

Race: ❑ Black ❑ White ❑ Native American ❑ Asian/Pacific Islander ❑ Other ❑ Unknown **Hispanic?** ❑ Yes ❑ No

CLINICAL

Diagnosis Date: / /

Diagnosing Physician Name:

Diagnosing Physician Phone #: ( )

Cough? ❑ Yes ❑ No
Onset: / /

Paroxysmal Cough? ❑ Yes ❑ No
Onset: / /

Whoop? ❑ Yes ❑ No **Apnea?** ❑ Yes ❑ No **Cyanosis?** ❑ Yes ❑ No
Nocturnal Cough? ❑ Yes ❑ No **Post-tussive vomiting?** ❑ Yes ❑ No

Pre-existing medical conditions? ❑Yes ❑ No **Specify:**

ED Visit? ❑Yes : ___/___/___ ❑No **Office Visit?** ❑Yes : ___/___/___ ❑No **Hospitalized?** ❑Yes ❑No **Admission Date:** ___/___/___

Currently Inpatient? ❑Yes ❑No **if yes, was patient isolated?** ❑Yes ❑No **Discharge Date:** ___/___/___

Hospitalized at: _____ **Died?** ❑Yes ❑No **Date Died:** ___/___/___

Complications: **Chest X-ray for pneumonia?** ❑ Negative ❑ Positive ❑ Not Done ❑ Unknown
Seizures due to pertussis? ❑ Yes ❑ No ❑ Unknown **Acute encephalopathy?** ❑ Yes ❑ No ❑ Unknown

CLINICAL CASE DEFINITION: ***A cough illness lasting ≥2 weeks with one of the following: paroxysms of coughing, inspiratory "whoop", or posttussive vomiting, without apparent cause.***

LABORATORY & TREATMENT

Lab Criteria: Isolation of B. Pertussis from a clinical specimen OR positive polymerase chain reaction (PCR) assay for B. Pertussis

Was laboratory testing done? ❑ Yes ❑ No ❑ Unknown **Lab used:**

	COLLECTION DATE	RESULT
❑ Culture	___/___/___	_____
❑ DFA	___/___/___	_____
❑ PCR	___/___/___	_____
❑ Serological 1	___/___/___	_____
❑ Serological 2	___/___/___	_____

Lab Result Codes:
P=Positive
N=Negative
E=Pending
I=Indeterminate
X=Not Done
S=Parapertussis
U=Unknown

Were antibiotics given? ❑ Yes ❑ No ❑ Unknown

	1st ANTIBIOTIC GIVEN:	2nd ANTIBIOTIC GIVEN:
Name/Code:		
Date first taken:	___/___/___	___/___/___
Total days taken:		

1-Erythromycin; 2-Cotrimoxazole (bact/sept); 3-Clarithromycin/azithromycin; 4-Tetracycline/doxycycline; 5-Amoxicillin/penicillin; 6-Other

VACCINATION HISTORY

Vaccinated? (Received any doses of diphtheria, tetanus, and/or pertussis-containing vaccines) ❑ Yes ❑ No ❑ Unknown
Reason Not Vaccinated with ≥3 Doses of Pertussis Vaccine
❑ **Religious** ❑ **Medical contraindications** ❑ **Parental refusal** ❑ **Inappropriate age** ❑ **Previous lab-confirmed disease** ❑ **Other**

	Date	Type*	Mfr.	Lot #		Date	Type	Mfr.	Lot #
1	___/___/___				4	___/___/___			
2	___/___/___				5	___/___/___			
3	___/___/___				6	___/___/___			

***Type: DTaP** (Infanrix®,Daptacel®,Tripedia®); **DTaP+Hib** (TriHiBit®); **DTaP+IPV+Hib** (Pentacel™) ; **DTaP+IPV** (Kinrix™); **Tdap** (Adacel®,Boostrix®)