KANSAS PERTUSSIS (WHOOPING COUGH) REPORTING FORM

Fax this form to your local health department or KDHE**:** 877-427-7318
Please include pertussis laboratory results, if available
This form is available at: www.kdheks.gov/epi/disease_reporting.html

Today's date: _____

PATIENT INFORMATION

Name: _____
Last *First* *Middle*

Mobile phone: _____ Home phone: _____

Residential address: _____

City: _____ State: _____ Zip: _____

Date of Birth (*if unknown, provide age*): _____

Race: ☐ White
☐ Black
☐ Asian
☐ American Indian / Alaska Native
☐ Native Hawaiian / Pacific Islander

Ethnicity: ☐ Hispanic
☐ Non-Hispanic

Sex: ☐ Male
☐ Female → Pregnant? ☐ Yes ☐ No ☐ Unknown

Associated with high-risk setting or institution? ☐ Daycare ☐ Health Care ☐ Food Handler ☐ School ☐ Nursing Home ☐ Correctional ☐ Shelter ☐ Other

Name and city of high-risk setting or institution: _____ Grade/Room: _____

DISEASE OR CONDITION INFORMATION

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

Hospitalized? ☐ Yes → Hospital: _____ Died? ☐ Yes
☐ No ☐ No
☐ Unknown

Laboratory name: _____ Specimen collection date: _____

Test(s) performed: _____ Test result(s): _____

FACILITY AND PHYSICIAN INFORMATION

Facility name: _____ Facility city: _____

Physician name: _____ Phone #: _____

Name of person reporting: _____ Phone #: _____

TREATMENT INFORMATION

Treated? ☐ Yes → Treatment type, dosage, and duration: _____
☐ No
☐ Unknown

PLEASE CONTINUE TO PAGE TWO FOR SUPPLEMENTAL INFORMATION FOR REPORTING PERTUSSIS

(Revised 05/2018)

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SUPPLEMENTAL PERTUSSIS INFORMATION – CLINICAL SYMPTOMS

Cough onset date: _____ Current cough duration: _____ days

Does patient present or report any of the following symptoms?

Paroxysmal cough (bursts of numerous, rapid coughs): ☐ Yes ☐ No ☐ Unknown

Inspiratory whoop: ☐ Yes ☐ No ☐ Unknown

Post-tussive emesis: ☐ Yes ☐ No ☐ Unknown

Infants younger than one year old, apnea: ☐ Yes ☐ No ☐ Unknown

Infants younger than one year old, cyanosis: ☐ Yes ☐ No ☐ Unknown

SUPPLEMENTAL PERTUSSIS INFORMATION – VACCINATION STATUS

Has patient previously received any pertussis-containing vaccine? ☐ Yes (enter below) ☐ No ☐ Unknown

Vaccine One date received: _____ Type (e.g. DTaP, Tdap): _____

Vaccine Two date received: _____ Type (e.g. DTaP, Tdap): _____

Vaccine Three date received: _____ Type (e.g. DTaP, Tdap): _____

Vaccine Four date received: _____ Type (e.g. DTaP, Tdap): _____

Vaccine Five date received: _____ Type (e.g. DTaP, Tdap): _____

Vaccine Six date received: _____ Type (e.g. DTaP, Tdap): _____

If unimmunized (or under-immunized), please select reason(s) below:

☐ Medical contraindication ☐ Religious exemption ☐ Parental objection ☐ Alternative immunization schedule

☐ Philosophical objection ☐ Under age for vaccination (younger than 2 months) ☐ Unknown/other

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

*High-risk persons are defined as:

- Infants younger than one;
- Pregnant women in third trimester;
- Persons with pre-existing health conditions that may be exacerbated by a pertussis infection;
- Persons exposed to patient that have regular contact with any high-risk persons above;

Please note, your local health department can assist in identifying high-risk contacts

Was chemoprophlaxis given/recommended to ALL household contacts and high-risk contacts? ☐ Yes ☐ No ☐ Unknown

If yes, please list names/relationships: _____

_____

_____