KANSAS PERTUSSIS (WHOPPING COUGH) REPORTING FORM

Fax this form to UG PHD: 913-573-6744 or KDHE: 877-427-7318

Please include Pertussis laboratory results, if available

To report urgent diseases, call the KDHE Epidemiology Hotline: 877-427-7317

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  □ Nursing Home  □ Health Care  □ Food Handler  □ School

□ 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  □ No  □ Unknown

Hospital: ____________________________

Died? □ Yes  □ 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  □ No  □ Unknown

Treatment type, dosage, and duration: ____________________________
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 chemoprophylaxis given/recommended to ALL household contacts and high-risk contacts? □ Yes □ No □ Unknown

If yes, please list names/relationships: ________________________________________________________________________________

______________________________________________________________________________