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 ☐ 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:** ______________________
☐ No
☐ Unknown

Died? ☐ Yes ☐ No

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

(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 persongs 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: ____

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(Revised 05/2018)