



DATE REPORTED (YYYY / MM / DD)	DATE CONTACTED (YYYY / MM / DD)	FORM COMPLETED BY
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REPORTING SOURCE  
 PROV LAB    PRIVATE LAB    HOSPITAL    PHYSICIAN    OTHER HEALTH CARE PROFESSIONAL    OTHER

**A. DEMOGRAPHIC INFORMATION**

CASE SURNAME	FIRST NAME	INITIAL	PHN
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BIRTHDATE (YYYY / MM / DD)	AGE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	PARENT / GUARDIAN (IF APPLICABLE)
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ADDRESS	PHONE # (INCLUDE AREA CODE)
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PHYSICIAN SURNAME	INITIAL	CITY	PHONE # (INCLUDE AREA CODE)
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PHN DISCUSSED WITH PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE (YYYY / MM / DD)
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**B. IMMUNIZATION HISTORY**

HAVE APPROPRIATE NUMBER OF DOSES OF PERTUSSIS VACCINE BEEN GIVEN? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATES IF AVAILABLE:		(YYYY / MM / DD)	(YYYY / MM / DD)
	(YYYY / MM / DD)	(YYYY / MM / DD)	(YYYY / MM / DD)	(YYYY / MM / DD)

**C. CASE DETAILS**

ONSET OF SYMPTOMS (CATARRHAL STAGE) (YYYY / MM / DD)	ONSET OF PAROXYSMAL COUGH (YYYY / MM / DD)	INFECTIOUS PERIOD: FROM (YYYY / MM / DD)	TO (YYYY / MM / DD)
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TYPE OF SYMPTOMS <input type="checkbox"/> COUGH LASTING ≥ 2 WEEKS <input type="checkbox"/> PAROXYSMAL <input type="checkbox"/> COUGH ENDING IN VOMITING OR ASSOCIATED WITH APNEA <input type="checkbox"/> COUGH WITH INSPIRATORY WHOOP	THIS CASE IS <input type="checkbox"/> CONFIRMED <input type="checkbox"/> PROBABLE <input type="checkbox"/> SUSPECT
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SEEN BY PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE SEEN (YYYY / MM / DD)	LAB CONFIRMED <input type="checkbox"/> YES <input type="checkbox"/> NO	PCR DATE (YYYY / MM / DD)	CULTURE DATE (YYYY / MM / DD)
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LINK TO ANOTHER CASE? (CONFIRMED OR PROBABLE) <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE OF LAST CONTACT (YYYY / MM / DD)	WITH WHOM? (SEE CONTACT SHEET)
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TREATED WITH ANTIBIOTICS <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE STARTED (YYYY / MM / DD)	NAME OF ANTIBIOTIC	X	DAYS
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**D. CONTACTS**

Antibiotics for prophylaxis should be given as soon as possible and not later than 21 days after the first contact with a case during the infectious period.

DOES CASE ATTEND DAYCARE*, PRESCHOOL* OR SCHOOL*? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, NAME OF FACILITY	GRADE	<b>*Notify daycare/preschool/school</b>
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**E. CONSIDER FOR CHEMOPROPHYLAXIS**

PLEASE CHECK ALL APPLICABLE CONTACTS:

<input type="checkbox"/> INFANT LESS THAN 1 YEAR OLD	<input type="checkbox"/> HOUSEHOLD CONTACT(S) INCLUDING FAMILY DAYCARE OR GROUP DAYCARE ATTENDEES WHERE THERE IS AN INFANT LESS THAN ONE YEAR OF AGE OR A PREGNANT WOMAN IN THE THIRD TRIMESTER
<input type="checkbox"/> PREGNANT WOMAN IN THIRD TRIMESTER	
<input type="checkbox"/> ANYONE UNIMMUNIZED	<input type="checkbox"/> OTHER:

*If indicated ANY of the above, list on contact sheet and do appropriate follow-up.*

<input type="checkbox"/> FOI DISCUSSED WITH CLIENT	<input type="checkbox"/> HEALTH TEACHING DONE
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NOTES (IF MORE ROOM REQUIRED, USE BACK OF THIS FORM)