Pertussis Enhanced Surveillance Form

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

hpsc

ID No. | HSE Area | CCA

Patient Name

Address

Phone No. | Mobile No.

School/college address | Work address

Sex: **M** **F** **NK** DOB | Age (Please state whether **Months or Years**) | Country of birth | Ethnicity

Reporting GP/Consultant/Lab/Hospital | Date of notification

CLINICAL DETAIL

Date of onset | Duration of cough (days) at 1st interview

	Yes	No	NK
Paroxysmal cough?			
Any cough?			
Any inspiratory whoop?			
Post-tussive vomiting?			
Apnoea?			
Cyanosis?			
Choking episodes (infant)?			

Other symptoms, please specify

Any underlying illness?- specify

COMPLICATIONS

	Yes	No	NK
Hospitalised			
Seizures			
Pneumonia			
Acute encephalopathy			
Conjunctival haemorrhages			

If other complications, please specify

Name of clinician

Hospital of admission (current)

Date of first admission | Date of discharge

If admitted to ICU, no of days

Outcome: 1. Died 2. Long-term sequelae 3. Lost to follow-up 4. Recovering 5. Recovered 6. Still ill 7.Not known

Date of death

Cause of death

EPIDEMIOLOGICAL

Date investigation started

	Yes	No	NK
Is case epi-linked to other case(s)?			

If outbreak related, please give OB identifier

Likely setting of exposure (if known): 1. Home 2. Other family setting 3. Creche/child care 4. School 5. Social setting 6. Health care associated 7. Work 8. Other 9. Unknown

If healthcare associated, please give name of facility

Likely source - specify if known: 1. Mother 2. Father 3. Sibling 4.Other relative 5.Health care worker 6. Other 7. Unknown

Age of source

ANTIBIOTIC TREATMENT

	Yes	No	NK	Name of antibiotic	Date antibiotic started
Was antibiotic given?					
Was 2nd antibiotic given?					

VACCINATION

Vaccination status*: Complete* | Incomplete* | Unvaccinated* | Unknown

Number of doses of Pertussis-containing vaccine | Please record 0, 1, 2, 3, 4, 5, 6 or U (for Unknown)

	Date vaccination	Manufacturer	Batch Number
Date 1st dose			
Date 2nd dose			
Date 3rd dose			
Date 4th dose			
Date 5th dose			
Date 6th dose			

Vaccination Information Source

1. GP record
2. HSE record
3. Parent recall
4. Parent record
5. Self report
6. Other
7. Unknown

If not vaccinated, what was the reason?

*Please see clarification of complete and incomplete vaccination status on the last page of the form

If you have direct access to CIDR, please enter these enhanced data, otherwise please forward this completed form to your local Department of Public Health who will enter it on your behalf

10/07/2018 version 1.8

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INFANT CASE *(If case is an infant please supply additional information)*

Was mother vaccinated during pregnancy? **Yes** ☐ **No** ☐ **NK** ☐

If yes, no. of weeks gestation at time of vaccination ☐ Gestational age at birth (weeks) ☐

Was the child breastfed at the time of onset **Yes** ☐ **No** ☐ **NK** ☐

If yes, frequency of breastfeeding Exclusively breastfed ☐ Partial breastfed ☐ Occasional breastfeed ☐

LABORATORY

Please specify which of the following tests were done and the results

Test	Result				Sample site	Yes	No	If not nasopharyngeal, please specify site
	Pos	Neg	Not Done	NK				
Culture	☐	☐	☐	☐	Nasopharyngeal swab/aspirate	☐	☐	☐
B. pertussis PCR	☐	☐	☐	☐	Nasopharyngeal swab/aspirate	☐	☐	☐

If PCR done, which targets: ☐ 1. IS481 target; 2. ptxP promoter target; 3. PT gene

Serology **Pos** ☐ **Neg** ☐ **Not Done** ☐ **NK** ☐

If serology done

Please specify the name of the kit used for serology ☐

(Note: diagnostic serology cannot validly be interpreted for one year after vaccination with accellular pertussis (aP) vaccines)

Please specify results of serology tests

1. IgG-anti-PT* (ELISA or multiplex immunoassay) **Pos** ☐ **Neg** ☐ **Equivocal** ☐

**using purified PT as antigen*

Please specify IgG titre result ☐

2. IgA-anti-PT* **Pos** ☐ **Neg** ☐ **Equivocal** ☐

**should only be used with indeterminate IgG-anti PT levels or when a second sample cannot be obtained*

Please specify IgA titre result ☐

Was sample sent to Reference Laboratory? **Yes** ☐ **No** ☐ **NK** ☐ If yes, please give Reference Laboratory name ☐

If Molecular typing was done please specify test and result

Test	Result
PFGE	☐
MLST	☐
MLVA	☐
DNA sequencing	☐
Other, specify	☐

FINAL CASE CLASSIFICATION

Confirmed ☐ Probable ☐ Possible ☐

FORM COMPLETION

Form completed by: ☐ **Date of completion** ☐

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HSE Area Use Only - This page is not forwarded to HPSC

***The following guidance is for completing the pertussis Vaccination status field for pertussis cases notified from 2013**

Age at time of onset/notification	Vaccination Status		
	Complete (No. doses)	Incomplete (No. doses)	Unvaccinated (No. doses)
<6 months	3	<3	0
6 months to <6 years	≥3	<3	0
6 years to ≤11 years	≥4	<4	0
12+ years and born since 1st september 2000	≥5	<5	0
Born between 1st September 1996 and 31st August 2000	≥4	<4	0
Born before 31st August 1996	≥3	<3	0

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Testing for other pathogens

Was testing for other microorganisms undertaken (as differential diagnosis)? Yes ☐ No ☐ NK ☐

If yes were any of the following positive? (tick **v** as appropriate)

Adenovirus ☐ Chlamydophila pneumoniae ☐ Coronaviruses ☐ Human metapneumovirus ☐

Influenza A or B ☐ Mycoplasma pneumonia ☐ Parainfluenza 1, 2 and 3 ☐ RSV ☐

Rhinovirus ☐

HSE Area information

(please include: any social event the cases participated in; main activities, like sport and sport clubs, volunteering, course and so on, with the name and address of the setting; missed opportunities for prevention of this case.)

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