Unique Case ID (*Study, Hospital, Lab no.):*

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division in the National Health Laboratory Service

Pertussis Case Investigation Form

Laboratory-confirmed case □ Probable case □ Suspected case □ Asymptomatic contact □

A) Individual Details: *(All cases/contacts)*

1. First Name: _____ Surname: _____
2. Sex: Male □ Female □
3. Date of birth: _____/_____/_____ (dd/mm/yyyy)
4. Age: _____ Years □ Months □ Weeks □ Days □
5. City/town of residence:_____
6. Province of residence:_____
7. If contact of a case,

   a) Name of contact:_____ b) Age of contact:_____

   c) Relationship of contact to case: _____

B) Symptoms: *(All cases/contacts)*

8. Did the individual have any pertussis-related symptoms? Yes □ No □ Not known □
9. If yes, date of first symptom onset: _____/_____/_____ (dd/mm/yyyy)
10. If yes, indicate specific symptoms experienced (mark all that apply):

Cough	Yes □	No □	Not known □
If yes, duration of cough: _____ days			
Paroxysmal cough (rapid and numerous bouts of cough):	Yes □	No □	Not known □
Inspiratory whoop (high pitched gasp for air after bouts of cough):	Yes □	No □	Not known □
Post-tussive vomiting (vomiting after bouts of cough):	Yes □	No □	Not known □
Apnoea (infants aged <1 year only, stopping breathing for short periods):	Yes □	No □	Not known □

Other symptoms-please specify: _____

C) Underlying medical conditions: *(All cases/contacts)*

11. Please indicate if the individual has any underlying medical conditions (mark all that apply):

Chronic respiratory disease (incl. asthma) □ Chronic heart disease □

Diabetes □ Pregnant □

HIV infection□ TB □

Immunosuppression (e.g. chemotherapy, organ transplant) □

Other medical condition- please specify: _____

Unique Case ID (*Study, Hospital, Lab no.):*

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division in the National Health Laboratory Service

D) Vaccination history *(All cases/contacts)*

12. Was the individual immunised against pertussis? Yes □ No □ Not known □

Vaccine dose	**Was pertussis vaccine received?**	**Date received** (dd/mm/yyyy)
1st Dose	Yes □ No □ Not known □	
2nd Dose	Yes □ No □ Not known □	
3rd Dose	Yes □ No □ Not known □	
4th Dose	Yes □ No □ Not known □	
Booster dose	Yes □ No □ Not known □	

E) Specimen Details *(Symptomatic individuals)*

13. Date of first specimen collection: _____/_____/_____(dd/mm/yyyy)
14. Specimen type: NPS/NPA □ Sputum □ Tracheal aspirate □ Other-please specify_____
15. Specimen laboratory number: _____
16. Testing laboratory:_____

F) Healthcare and Outcome: *(Symptomatic individuals)*

17. Did the individual seek care for the illness? Outpatient □ Inpatient □ No care sought □ Not known □
18. If yes, facility name _____
19. Did the individual receive azithromycin or another macrolide? Yes □ No □ Not known □
20. Outcome of illness: Recovered □ Still sick □ Died □ Not known □
21. Date of outcome: _____/_____/_____ (dd/mm/yyyy)

Form completed by: _____

Contact no: _____

Date of interview: _____(dd/mm/yyyy)