### Pertussis Reporting Form for Healthcare Providers

**Notifiable Condition:**  Pertussis

**Today’s Date:**  ___/___/___

**Date of Diagnosis:**  ___/___/___

**Patient Name:**  ___________________________________________  

**Date of Birth:**  ___/___/___  ☐ Female  ☐ Male

**Address:**  ___________________________________________

Street  City  Zip

**Phone:**  Home (______)(______)_________  Cell: (______)(__________)

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<table>
<thead>
<tr>
<th>Additional Client Information Needed for Case Report:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race:</strong>  ☐ American Indian or Alaskan Native  ☐ Asian  ☐ Black or African American  ☐ Native Hawaiian or other Pacific Islander  ☐ White or Caucasian  ☐ Other Race: ________________________</td>
</tr>
<tr>
<td><strong>Hispanic:</strong>  ☐ Yes  ☐ No</td>
</tr>
</tbody>
</table>

**Client Occupation or School & Grade:**  ____________________________

**Name of Parent/Caregiver if patient is under 18:**  ___________________________________________

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**Onset date of symptoms:**  ___/___/___  

**Date seen in office:**  ___/___/___

**ER visit date:**  ___/___/___  

**Date of hospital admission:**  ___/___/___

**Lab test and results:**  (fax copy to (360) 385-3878)  

**Attending Health Care Provider:**  (Please PRINT Name)

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**Symptoms:**

☐ Fits of Coughing

☐ Vomiting Due to Cough

☐ Whoop

**Treatment:**

**Medication** ___________________________________________  

**Date of treatment:**  ___/___/___

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**Possible exposures, including recent travel:**

Have any infants < 1 year or pregnant women been exposed to this patient?  ☐ Yes  ☐ No

**Are you providing prophylactic treatment to any contacts? Please list names**

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**Other pertinent information, including predisposing conditions:**

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Name of person completing form (please print)  Signature  Phone

When possible, please let your patient know that their condition is reportable to the Health Department and that a public health nurse will be contacting them to gather additional information about their illness. Informing your patient about the importance of this reporting process will help us to assess possible exposures and recommend specific steps to take to prevent disease transmission. We appreciate your help.

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**PLEASE FAX THIS FORM TO:**  (360) 385-3878.  **Questions:**  (360) 385-9400  **THANK YOU!**

Revised 9-28-16