



# PERTUSSIS HOSPITALIZATION ADDENDUM

To be used by Local Health Jurisdictions to report to CDPH

California Dept. of Public Health  
Immunization Branch  
850 Marina Bay Parkway  
Building P, 2<sup>nd</sup> Floor, MS 7313  
Richmond, CA 94804-6403  
Fax: (510) 620-3949

## PATIENT DEMOGRAPHICS

Patient's name (last, first, middle initial)	DOB (month /day /year) / /	Age (enter age and check one) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
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## HOSPITALIZATION / COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized ( $\geq 24$ hours) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Dates hospitalized / / to / /	Total # days hospitalized	Hospital name	
Name of contact	Phone	Intubated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days intubated	
Patient in ICU <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days in ICU	Receive nitric oxide <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Receive exchange transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Receive ECMO <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Days on ECMO	Received medical care for pertussis prior to hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, number of medical visits	Date of first medical visit / /	
Seizures due to pertussis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute encephalopathy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chest x-ray for pneumonia <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unknown	Pulmonary hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, describe:	Death* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes, date of death / /	

**\*If died, please notify CDPH immediately**

## INVESTIGATION NOTES:

## CASE INVESTIGATION

Local Health Jurisdiction	Case Investigator name	LHD Case ID Number	CalREDIE Incident Number
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