# PERTUSSIS INVESTIGATION FORM

Personal health information is being collected under the *NWT Health Information Act* and the *Public Health Act* and will not be used or disclosed, unless allowed or required by these Acts or any other Act

## SECTION 1- PATIENT INFORMATION

| **Last Name:** | **First Name:** | **Birthdate** (D/M/Y)**:** |
|---|---|---|
| **HCN:** | **Sex at Birth:** ☐Male ☐Female | **Preferred Method of Contact**: ☐Phone ☐Email |
| **Current Address/Community:** | | |
| **Phone Number:** | **Email Address/Other Contact Number:** | |

## SECTION 2 – INITIAL ASSESMENT AND TREATMENT

**Detailed History of Illness:** onset date, duration, concurrent illness, travel history, exposure history, etc.

**Symptom Onset** (D/M/Y): _____

**Exposed to Confirmed Case**: ☐No ☐Yes, Where/When:_____

**Describe Type of Cough and Length in Detail:**

**Cough Onset** (D/M/Y): _____

| **Symptoms:** | **Yes** | **No** |
|---|---|---|
| Cough | ☐ | ☐ |
| Cyanosis | ☐ | ☐ |
| Cough ending in: | | |
| Whoop | ☐ | ☐ |
| Vomiting/gagging | ☐ | ☐ |

Other: _____

**Underlying Illness:**

**Present Treatment/Prophylaxis** (Type and date)**:**

**Hospitalized:** ☐No ☐Yes, **Healthcare Facility:** _____ **Date: Admission**_____ **Discharge** _____

**If Yes, List Drugs** (length and date of treatment):

**Laboratory/Radiological Investigation:**

Type: Date (D/M/Y): Result:

(Nasopharyngeal Swab in Regan-Lowe Transport Medium)

**Immunization with Pertussis-containing Vaccine:** Number of Doses: _____ Date of Last Dose (D/M/Y):_____

**Contacts:** List on separate Pertussis Contact Sheet and fax to OCPHO

**Recent Activities:** (Use timeline on reverse side)

**Frequent Contact with Vulnerable People**: ☐Yes ☐No

Vulnerable people include immunocompromised OR infant less than 1 year of age OR pregnant in third trimester (due to risk of transmission to newborn.

**Daycare:** ☐Yes ☐No **School:** ☐Yes ☐No

**Other**: _____

**Complications/Sequelae (of illness):**

**Comments and Actions Taken:**

**Self-Isolation:** ☐No ☐Yes, Length: _____

**Informed:** ☐ Local Public Health ☐OCPHO Other: _____

**Follow-up Recommended:**

## SECTION 3 – ADDITIONAL INFORMATION/REPORTING

**Office of the Chief Public Health Officer | Department of Health and Social Services**
**Box 1320, Yellowknife NT X1A 2L9 | Phone (867) 920-8646 | Fax: (867) 873-0442**

| **Completed by** (print): | (sign): |
|---|---|
| **Phone:** | **Date (D/M/Y):** |
| **Comments:** | |

| HCN: | Last Name: | First Name: |
|---|---|---|

Date of Exposure if Known (D/M/Y): _____

| | | Day | Activity/Symptom Details |
|---|---|---|---|
| Infecttious Period | Catarrhal Stage | Day -10 | |
| | | Day -9 | |
| | | Day – 8 | |
| | | Day – 7 | |
| | | Day – 6 | |
| | | Day – 5 | |
| | | Day – 4 | |
| | | Day – 3 | |
| | | Day – 2 | |
| | | Day – 1 | |
| | Paroxysmal Stage | **Day 0 (Cough Onset)** | |
| | | Day 1 | |
| | | Day 2 | |
| | | Day 3 | |
| | | Day 4 | |
| | | Day 5 | |
| | | Day 6 | |
| | | Day 7 | |
| | | Day 8 | |
| | | Day 9 | |
| | | Day 10 | |
| | | Day 11 | |
| | | Day 12 | |
| | | Day13 | |
| | | Day 14 | |
| | | Day 15 | |
| | | Day 16 | |
| | | Day 17 | |
| | | Day 18 | |
| | | Day 19 | |
| | | Day 20 | |
| | | Day 21 | |

Notes: