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| **Notification Details** | | Primary care practitioner | | | | | | | | Hospital practitioner | | | | | | | | | | | | | | | | | | Other | | | | | | |
| **Name of person notifying** | | **Add name** | | | | | | | | | | | | | | | | | | | **Date reported** | | | | | | | **Click for date** | | | | | | |
| **Organisation** | | **Enter organization name** | | | | | | | | | | | | | | | | | | | **Phone** | | | | | | | **Organisation phone** | | | | | | |
| **Usual GP & Practice** | | **GP name** | | | | | | | | | | | | | | | | | | | **GP Phone** | | | | | | | **GP phone** | | | | | | |
| **CASE CLASSIFICATION** | | **Contact with lab confirmed case?** | | | Yes | | | | | | No | | | | | | | | | | **Name of confirmed case: Add name** | | | | | | | | | | | | | |
| **Patient details and risk factors** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of case** | | **Surname** | | | | | | | | | | | | | **Given name(s)** | | | | | | | | | | | | | | | | | | | |
| **NHI Number** | | **Add NHI #** | | | | | **Date of birth** | | | | | | | | **Add DOB** | | | | | | | | | | | **Gender** | | | **Select from list** | | | | | |
| **Address** | | **Add address** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Phone (home)** | | **Add phone #** | | | | | **Phone (work)** | | | | | | | | | **Add alt #** | | | | | | | | | | **Mobile** | | | **Add mobile #** | | | | | |
| **Ethnicity** | | **Choose an item** | | | | | | | | | | | | | | | **Other, please specify** | | | | | | | | | | | | | | | | | |
| **Attends/works at ELS, Education or Healthcare Facility (required):** | | Yes | | No | | **If Yes, name & area of facility: Add name and area Dates attended in the last 7 days: Add dates** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pregnant** | | Yes | | No | | **Infants <12M** | | | | | | | | Yes | | | | | | No | |  | | | | | | | | | | | | |
| **Vaccination history** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Age appropriately immunised?** | | Yes | | No | | **Not immunised?** | | | | | | | | Yes | | | | | No | | | | **Given adult Boostrix in past 5 years?** | | | | | | Yes | | | | | No |
| **BASIS OF DIAGNOSIS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Coryza / catarrhal prodrome (UTRI symptoms and non-specific cough)?** | | | | Yes | | No | | | | | | | **Date of onset:**  **Click for date** | | | | | | | | | | | | | | | | | | | | | |
| **Coughing fits (paroxysmal cough)?** | | | | Yes | | No | | | | | | | **If Yes, date of onset:**  **Click for date** | | | | | | | | | | | | | | | | | | | | | |
| **Inspiratory whoop?** | | | | Yes | | No | | | | | | | **In the clinician’s opinion is this illness clinically compatible with pertussis?** | | | | | | | | | | | | | | | | | Yes | | | | No |
| **Post-tussive vomiting or apnoea?** | | | | Yes | | No | | | | | | |
| **Laboratory investigations carried out? PCR preferable if taken within first 3 weeks.** NB Serology not helpful in confirming diagnosis or immunity unless paired sera are taken > 2 weeks apart. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | No | |
| **PCR** | | | Yes | | No | | | | | | | Result: **Add results details** | | | | | | | | | | | | | | | | | | | | | | |
| **Culture** | | | Yes | | No | | | | | | | Result: **Add results details** | | | | | | | | | | | | | | | | | | | | | | |
| **Serology** | | | Yes | | No | | | | | | | Result: **Add results details** | | | | | | | | | | | | | | | | | | | | | | |
| **CLINICAL mANAGEMENT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Antibiotics prescribed?** | | | If Yes, select below | | | | | | | | | | | | | | | No | | | | | | | | | | | | | | | | |
| **Azithromycin** | | | | | | Yes | | | | | | | | | No | | | | | | | | | Date: **Click for date** | | | | | | | |
| **Erythromycin** | | | | | | Yes | | | | | | | | | No | | | | | | | | | Date: **Click for date** | | | | | | | |
| **Exclusion advice provided?** | | | Yes | | | | | | No | | | | | | | | | **Hospitalised** | | | | | | | | | Yes | | | | | No | | |
| **MANAGEMENT OF HOUSEHOLD CONTACTS - *Please refer to*** [***ARPHS’ Pertussis Clinical Pathway***](https://www.arphs.health.nz/our-resources/clinical-pathway-pertussis/download?files=1313) ***for the appropriate action.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Any high priority  household contacts?** | If yes,  select below | | No | | | | | | **Prophylactic antibiotics prescribed?** | | | | | | | | | | | | | | | | **Azithromycin** | | | | | | Yes | | | No |
| **Erythromycin** | | | | | | Yes | | | No |
| <12 months old | | | | | | | Work with <12 month olds | | | | | | | | | | | | | | | | Pregnant in 3rd trimester | | | | | | | | | | |

**Thank you for completing this form. You may be contacted by ARPHS for further information.  
Email to ARPHS at** [**notify@adhb.govt.nz**](mailto:notify@adhb.govt.nz)