



## CDC • National Center for Immunization and Respiratory Diseases PERTUSSIS DEATH WORKSHEET



This supplemental worksheet should be used for all known laboratory-diagnosed or epidemiologically-linked pertussis-related deaths, whether or not the decedent meets the CSTE pertussis case definition requirements for reporting. This worksheet is not intended for use among decedents with clinical suspicion of pertussis in the absence of laboratory testing or epidemiologic linkage to another laboratory-confirmed case. At a minimum, pertussis should be listed as a discharge diagnosis, cause of death, or contributing condition. Information for this worksheet should be obtained from surveillance case investigations, hospital records, and/or death certificates. Where appropriate, this information should match the information reported through NNDSS to CDC.

**Decedent State of Residence:** \_\_\_\_\_

Decedent Information	
State surveillance ID (if reported)	
County of residence	
State where death occurred	
Date of birth	
Country of birth	
Gestational age at birth (decedents <1 year of age only) <sup>†</sup>	
Cough onset date*	
Date of death	
Sex	
Race	
Ethnicity	

<sup>†</sup> Gestational age should be reported in weeks and should reflect the number of completed weeks of gestation at the time of death.

\* If cough not apparent (e.g. infants presenting with apnea, cyanosis, etc.) enter date of symptom onset.

### Clinical Symptoms, Complications, Lab Testing and Epidemiologic Linkage, check all that apply:

**Clinical symptoms**     Cough     Paroxysms     Post-tussive vomiting     Whoop     Apnea  
 Cyanosis     Fever     Rhinorrhea     Other: \_\_\_\_\_     None

**Cough duration (days)** \_\_\_\_\_     Unknown

**Pertussis laboratory results**     Culture<sup>+</sup>     PCR<sup>+</sup>     Serology<sup>+</sup>  
 Respiratory Panel\*: \_\_\_\_\_     Other: \_\_\_\_\_

**Is an isolate or specimen available to send to CDC?**     Yes     No     Unknown

**Complications experienced**     Pneumonia     Encephalopathy     Seizures     Lymphocytosis  
 Other: \_\_\_\_\_     None

**Was decedent hospitalized?**     Yes     No     Unknown

If yes, dates of hospital admission and discharge or death: \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_

**Treatments/Interventions**     Antibiotics    Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_     Intubation    Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ECMO    Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_     Other (specify): \_\_\_\_\_    Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 None     Unknown

**Epi-linked to a lab-confirmed case?**     Yes     No     Unknown

**Family history of cough?**     Yes     No     Unknown

**Underlying Health Issues, check all that apply:**  None  Unknown

Please select any chronic or acute health conditions that the decedent had prior to his/her pertussis infection.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS or CD4 count <200   | <input type="checkbox"/> Emphysema/COPD  | <input type="checkbox"/> Peripheral neuropathy              |
| <input type="checkbox"/> Alcohol abuse, current   | <input type="checkbox"/> Heart failure/CHF   | <input type="checkbox"/> Plegias/paralysis                  |
| <input type="checkbox"/> Alcohol abuse, past  | <input type="checkbox"/> HIV infection   | <input type="checkbox"/> Pulmonary hypertension             |
| <input type="checkbox"/> Aspiration, history of   | <input type="checkbox"/> Hodgkin's Disease/lymphoma                                | <input type="checkbox"/> Reactive airway disease            |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Immunoglobulin deficiency                                 | <input type="checkbox"/> Seizure/seizure disorder           |
| <input type="checkbox"/> Atherosclerotic Cardiovascular Disease/CAD   | <input type="checkbox"/> Immunosuppressive therapy<br>(steroids, chemo, radiation) | <input type="checkbox"/> Sickle cell anemia                 |
| <input type="checkbox"/> Bone marrow transplant (BMT)   | <input type="checkbox"/> IVDU, current*  | <input type="checkbox"/> Smoking, current*                  |
| <input type="checkbox"/> Bronchopulmonary dysplasia (BMD), history<br>of (also called chronic lung disease (CLD)) | <input type="checkbox"/> IVDU, past*   | <input type="checkbox"/> Smoking, past*                     |
| <input type="checkbox"/> Cerebral vascular accident/stroke  | <input type="checkbox"/> Leukemia  | <input type="checkbox"/> Solid organ malignancy             |
| <input type="checkbox"/> Chronic kidney disease   | <input type="checkbox"/> Multiple myeloma  | <input type="checkbox"/> Solid organ transplant             |
| <input type="checkbox"/> Cirrhosis/liver failure  | <input type="checkbox"/> Multiple sclerosis  | <input type="checkbox"/> Splenectomy/asplenia               |
| <input type="checkbox"/> Complement deficiency  | <input type="checkbox"/> Nephrotic syndrome  | <input type="checkbox"/> Systemic lupus erythematosus (SLE) |
| <input type="checkbox"/> Congenital heart disease   | <input type="checkbox"/> Neuromuscular disorder                                    | <input type="checkbox"/> Other chronic lung conditions      |
| <input type="checkbox"/> Current chronic dialysis   | <input type="checkbox"/> Obesity   | <input type="checkbox"/> Other prior illnesses:             |
| <input type="checkbox"/> Cystic fibrosis  | <input type="checkbox"/> Other drug use, current*                                  | _____   |
| <input type="checkbox"/> Dementia   | <input type="checkbox"/> Other drug use, past*                                     | _____   |
| <input type="checkbox"/> Diabetes mellitus  | <input type="checkbox"/> Parkinson's Disease                                       | _____   |

\*Current = within the previous 12 months. Past = more than 12 months ago.

**Co-Infections and Other Diagnoses, check all that apply:**  None  Unknown

Please select any diagnoses or other infections identified via laboratory testing during the decedent's pertussis illness.

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Respiratory Syncytial Virus (RSV) | <input type="checkbox"/> Influenza B                  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Rhinovirus                        | <input type="checkbox"/> Parainfluenza                | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Coronavirus                       | <input type="checkbox"/> human Metapneumovirus (hMPV) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Influenza A                       | <input type="checkbox"/> Adenovirus                   |                                       |

**Decedent Pertussis Vaccination History (complete if not already available on surveillance case report form)**

Unvaccinated  Unknown

Dose	Vaccine (DTP, DTaP, Tdap, etc.)	Date Administered	Manufacturer/Lot #
1			
2			
3			
4			
5			
6			
7			
8			

Data should be obtained from: provider medical records, immunization registries, shot cards/other family records, patient/parent report (no record), or school records.

**Maternal History (For pertussis decedents <12 months of age only)**

Maternal date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Maternal Tdap History (For pertussis decedents <12 months of age only)**

Unvaccinated     Unknown

Dose	Date Administered	Pregnancy Status at Administration**	If Pregnant at Administration, Week of Pregnancy±	Manufacturer/Lot #
1				
2				
3				
4				

\*\*Pregnancy status responses include: Pregnant, Post-Partum, and Neither.  
± Fill in the number of completed weeks of pregnancy at the time of mother's Tdap administration.

**Maternal Childhood Pertussis Vaccination History (For pertussis decedents <12 months of age only)**

Unvaccinated     Unknown

Dose	Vaccine (DTP, DTaP, Tdap, etc.)	Date Administered	Manufacturer/Lot #
1			
2			
3			
4			
5			
6			

**Other Maternal Vaccination History During Pregnancy\* (For pertussis decedents <12 months of age only)**

No other vaccines received during pregnancy     Unknown

Dose	Vaccine (RSV, Flu, COVID-19)	Date Administered	Manufacturer/Lot #
1			
2			
3			
4			

\*Only include vaccines received during pregnancy with the decedent.

**Post Mortem Examination and Death Certificate Information**

Was a post-mortem exam done?     Yes     No     Unknown

Is death certificate available?     Yes     No     Unknown

Causes of death:     Unknown

- a. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_
- b. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_
- c. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_
- d. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_

Contributing conditions:     Unknown

- a. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_
- b. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_
- c. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_
- d. \_\_\_\_\_ ICD-10 code: \_\_\_\_\_