# **Notification of a pertussis cases in healthcare workers and of pertussis clusters in healthcare settings**

## Details for the first cluster case or a single HCW case

|  |  |  |
| --- | --- | --- |
| **Notification date** |  **\_\_\_\_/\_ /**  | Please complete this form for: any single case in a health care worker (HCW) who has direct patient contact and all clusters (2 or more cases) in a 21 day period in a healthcare setting. |
| **HPT** |  |
| **HPZone / CIMS case reference number** |  |
| **First name** |  |  \* Delete as appropriate. |  |  |
| **Surname** |  |  |  |  |
| **Sex** |  |  |  |  |
| **Date of birth** |  |  |  |  |
| **Setting type (for example. maternity ward, ICU, general practice)** |  | **Name of setting (for example, hospital name, practice name)** |  |
| **Was a sample sent for testing\*** | Yes / no | **Date** |  / /  | **Sample type\*** | Serum / NP swab / throat swab / oral fluid  |
| **Was contact tracing undertaken\*** | Yes / no |  |
| **If yes, number of contacts** |  | Please complete this form as fully as possible and email to:pertussis@ukhsa.gov.uk |
| **Number of contacts offered prophylaxis** |  |
| **Number of contacts offered vaccine** |  | Any queries please contact sonia.ribeiro@ukhsa.gov.uk |
| **Were any symptomatic contacts identified\*** | Yes / no |
| **If yes - number of symptomatic contacts** |  |  |

## Details for HCW case only

|  |  |
| --- | --- |
| **Type of HCW (for example, practice nurse, midwife, surgeon)** |  |
| **Does this HCW have direct patient contact with infants and/or pregnant women?\*** | Yes / no |

## Details of all subsequent clinically diagnosed cases with sample submitted for testing

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Cluster case 2** | **Cluster case 3** | **Cluster case 4** | **Cluster case 5** | **Cluster case 6** |
| **Contact or cluster case first name** |  |  |  |  |  |
| **Contact or cluster case surname** |  |  |  |  |  |
| **Contact or cluster case date of birth** |  |  |  |  |  |
| **Sample date** | \_\_\_\_/\_\_\_\_/\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_ |
| **Sample type delete as appropriate)** | Serum / NP swab / throat swab / oral fluid | Serum / NP swab / throat swab / oral fluid | Serum / NP swab / throat swab / oral fluid | Serum / NP swab / throat swab / oral fluid | Serum / NP swab / throat swab / oral fluid |
| **HPZone contact reference number** |  |  |  |  |  |
| **Nature of relationship (for example, patient, household)** |  |  |  |  |  |