PERTUSSIS SUPPLEMENTAL FORM
for cases <4 months of age

California Dept. of Public Health
Immunization Branch
850 Marina Bay Parkway
Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Fax: (916) 440-5973

Contact Mother of Infant Pertussis Case to complete Sections A and B

Section A.

Infant's name (*last, first, middle initial)*	Infant DOB *(mm/dd/yyyy)* / /	CalREDIE ID	Local ID
Mother's name (*last, first, middle initial)*	Mother DOB *(mm/dd/yyyy)* / /	CalREDIE ID *(if applicable)*	Local ID *(if applicable)*

Mother's ethnicity

☐ Hispanic/Latino
☐ Non-Hispanic/ Non-Latino
☐ Unknown

Mother's race (*check all that apply*)

☐ Black/African-American
☐ Native American/ Alaskan Native
☐ White
☐ Unknown
☐ Other:
☐ Asian (*please specify*)
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other Asian:

☐ Pacific Islander (*please specify*)
- ☐ Native Hawaiian
- ☐ Guamanian
- ☐ Samoan
- ☐ Other Pacific Islander:

A1. Do you live with your baby? ☐ Yes ☐ No If no, in which county do you reside? ☐ Unknown

Prenatal Care Information

A2. Who provided your prenatal care during this pregnancy? (If >1 practice, list others at bottom of page)	A3. Prenatal care practice name/location	A4. Prenatal care phone number

Mother's History

A5. Did you participate in WIC during this pregnancy?
☐ Yes– If yes, at what site? _____ ☐ No ☐ Don't know

A6. Did you receive Tdap (the shot that protects against whooping cough, tetanus, and diphtheria) during this pregnancy?
☐ Yes – If yes, during which trimester did you get it? ☐ First ☐ Second ☐ Third ☐ Don't know (If yes, skip to Section B)
☐ No
☐ Don't know
☐ Received it after delivery

A7. Did your prenatal care provider recommend that you receive Tdap during this pregnancy?
☐ Yes – If yes, why didn't you get it?
- ☐ I didn't want to get it – If so, why? _____
- ☐ I didn't or couldn't go to alternate site recommended
  What was alternate site? _____
- ☐ Insurance/payment issues (describe in detail): _____
- ☐ I delivered my baby before I could get it
- ☐ Other reason: _____

☐ No (Skip to section C)
☐ Don't know (Skip to section C)

A8. When your provider recommended the whooping cough shot, do you feel she/he gave you all of the information you needed?
☐ Yes
☐ No - If no, what was missing?_____

Section B. If mother received Tdap during this pregnancy, complete this section

B1. Where did you receive Tdap during this pregnancy?
☐ At a routine OB visit
☐ At a primary care physician visit
☐ At a pharmacy (specify name of pharmacy): _____
☐ At other site (specify name of site or clinician): _____
☐ Don't know

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Name of person completing mother's form:	Phone number and/or Email address:	Date mother's interview completed:
_____	_____	/ /

Other prenatal care provider practice(s) where care received during this pregnancy and their contact information.

Contact Prenatal Care Provider to complete Sections C and D

If mother received care at more than one practice, interview provider(s) who saw mother closest to 27-36 weeks gestation.

Section C.

Provider or Practice Name:	Name/phone number of person interviewed:
_____	_____ _____
C1. Is the provider a Comprehensive Perinatal Services Program (CPSP) provider? ☐ Yes ☐ No ☐ Unknown	C2. Prenatal care provider's NPI number: _____

C3. Prenatal care provider type: ☐ OB ☐ FP ☐ NP ☐ Nurse Midwife ☐ Other:

C4. Is this practice affiliated with one or more Medical Groups/IPAs? ☐ Yes - Specify name(s): _____
☐ No, this is a solo practice.

C5. What health insurance coverage did the mother have in the last 3 months of pregnancy? (if covered by more than one insurer during this time period, record insurance coverage closest to 27 weeks gestation)

☐ Private – Name of Company: _____ ☐ PPO ☐ HMO

☐ Medi-Cal – Client Identification Number: _____ ☐ Managed Care – Name of Plan _____
☐ Fee-for-Service

C6. What immunization(s), if any, does the prenatal care provider stock? ☐ Tdap ☐ Influenza (flu) ☐ Other: _____
☐ None

C7. Did the prenatal care provider recommend Tdap to the mother during this pregnancy?
☐ Yes – If yes, is there documentation in the patient's chart of a recommendation for Tdap? ☐ Yes ☐ No
☐ No – If no, why wasn't Tdap recommended to the mother? _____ (Skip to C9)
☐ Unknown (Skip to C9)

C8. Did the provider refer the mother to receive Tdap off-site?
☐ Yes – If yes, where was the mother referred? (please specify location): _____
Did you confirm that this site will administer Tdap to this patient? ☐ Yes ☐ No
☐ No, the provider offered Tdap on-site.
☐ No, there was no referral.

C9. Did the mother receive Tdap during this pregnancy?
☐ Yes ☐ No – If no, is there documentation in this patient's chart of the patient declining Tdap? ☐ Yes ☐ No (Skip to C15)
☐ Unknown (Skip to C15)
☐ Received it postpartum (Skip to C15)

C10. During which trimester and week of gestation was Tdap given?
Trimester: ☐ First ☐ Second ☐ Third
Date of vaccination: _____ Week of gestation: _____

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C11. Which Tdap vaccine was given? ☐ Adacel ☐ Boostrix ☐ Unknown

C12. Where was Tdap given?
- ☐ On-site at this clinic (skip to C15)
- ☐ At a pharmacy (specify name of pharmacy): _____
- ☐ At other site (specify name of site or clinician): _____
- ☐ Unknown

C13. Did the provider follow up on mother's receipt of Tdap? ☐ Yes – If yes, how? _____ ☐ No

C14. Is off-site receipt of Tdap documented in the mother's medical record? ☐ Yes ☐ No

C15. Does the provider recommend influenza vaccine to pregnant patients? ☐ Yes ☐ No–If no, why not? _____

STOP HERE IF MOTHER RECEIVED TDAP ON-SITE FROM THIS PROVIDER DURING THIS PREGNANCY

Section D. (The public health department may follow up with clinic for additional details.)

D1. Has Tdap ever been offered on-site?
☐ Yes ☐ No ☐ Unknown

D2. Why isn't Tdap offered at this clinic?
- ☐ Do not have storage capacity
- ☐ Refrigerator and related equipment too expensive
- ☐ Do not have time for vaccine management/administration
- ☐ Vaccine cost too high. Paid $_____per Tdap dose.
- ☐ Billing/coding too complicated
- ☐ Prenatal Tdap was not reimbursed/claims denied. Specify why _____
- ☐ Not financially sustainable with current reimbursement or contracting arrangements.
  If so, for which Managed Care Plans (specify) _____ and/or Medical Groups (specify) _____

  Please list which Managed Care Plans and/or Medical Groups include the cost of the vaccine dose in its capitation payments to your practice: _____

- ☐ Other: _____

D3. Would the clinic consider starting to provide Tdap on-site?
- ☐ No – If no, why not? _____
- ☐ Unsure
- ☐ Yes – If yes, what would the clinic need to get this started?
  - ☐ Training on vaccine storage/handling
  - ☐ Training on vaccine administration
  - ☐ Training on billing
  - ☐ Help purchasing refrigerator and related equipment
  - ☐ Help procuring vaccine at lower cost
  - ☐ Other: _____

D4. If there is no plan to offer Tdap on-site, will the clinic attempt to ensure that pregnant patients are receiving Tdap off-site?
☐ Yes ☐ No If yes, how? _____

Name of person completing Sections C and D:	Phone number and/or Email address:	Date provider's interview completed:
_____	_____	/ /

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Section E. Local Health Department (LHD) follow-up activities

What resources did you provide to this practice? _____

Please specify:

☐ No follow up planned

☐ My LHD will take these follow-up steps by when?

1. Activity _____ Date _____

2. Activity _____ Date _____

Instructions for LHD communicable disease staff:

1. Interview mother and complete Sections A and B
2. Contact the provider's office to complete Sections C and D. Note: Please prioritize complete responses for C2, C5, C6 and C9.
    a. Ask office manager or nurse about Tdap vaccination practices in office. Ask follow-up questions as needed, such as, 'What are the logistical challenges/barriers to stocking Tdap in your practice?'
    b. Validate whether mother received Tdap in office or not.
    c. Ask office staff to review mother's prenatal records for all visits during the third trimester (or 3 months before birth) to determine if there is documentation of offer (or refusal) of Tdap, if given on-site.
    d. If not given on-site, is there documentation of where the patient was referred, and if she actually did receive Tdap?
    e. If Tdap was not recommended or offered due to reimbursement issues, please request denied claims.
    f. If the mother saw two providers during her third trimester of pregnancy, interview both (time permitting) unless receipt or refusal of Tdap is documented during the first provider interview. Use additional forms as necessary.
    g. If off-site receipt of Tdap is not documented in the mother's chart (C14), consider looking up doses in CAIR and include note to indicate you looked up her record in CAIR.
3. Submit form to CDPH with infant's case report by uploading into CalRedie or faxing to CDPH within one month of when the case is first identified. Please prioritize sending these case reports.
4. Meet with local MCAH and Immunization program staff to
    a. Review the completed form, and
    b. Plan who will follow up with the provider (if needed) to address barriers to Tdap coverage now and 3 months later (to see if practice changed)
    c. Please communicate to CDPH what resources you offered providers, your follow-up activities, and any best practices identified during follow up – contact Amber Christiansen at amber.christiansen@cdph.ca.gov or (510) 620-3759.
5. Time-permitting, follow up with WIC sites where mothers are going to ensure WIC staff are providing education about prenatal Tdap or referral to local immunization clinics, as appropriate.

For questions on this form or process, contact Kathleen Winter at kathleen.winter@cdph.ca.gov or (510) 620-3770.