

Measles (Rubeola)

PATIENT DEMOGRAPHICS

Name (last, first): _____	*Birth date: __/__/____ Age: _____
Address: _____	*Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
City/State/Zip: _____	*Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
Phone (home): _____ Phone (work) : _____	*Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. (Mark all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk
Occupation/grade: _____ Employer/School: _____	
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____	

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigator : _____	WVEDSS ID: _____
Investigator phone: _____	Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
Investigation Start Date: __/__/____	

REPORTING SOURCE

*Date of report: __/__/____ Report Source: Laboratory Hospital Physician Public Health Agency Other

Report Source Name: _____ Address: _____ Phone: _____

Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____

Reporter Name: _____ Address: _____ Phone: _____

*CLINICAL

Physician Name: _____ Physician Facility : _____

Physician Address: _____ Phone: _____

Hospital *Was patient hospitalized for this illness? Y N U

If yes: Hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____

Condition Diagnosis date: __/__/____ * Illness onset date: __/__/____ Illness end date: __/__/____

Y N U

Did the patient have a rash? If yes: Rash onset date: __/__/____ Rash duration (in days) _____

Was the rash generalized? Y N U Celsius

Did the patient have a fever? If yes: Fever onset date: __/__/____ Highest measured temperature _____° Fahrenheit

Symptoms	Complications
Did the patient have any of the following: Y N U	Y N U
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Croup
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coryza (runny nose)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Otitis media
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Conjunctivitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pneumonia
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Encephalitis
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Thrombocytopenia
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other (specify): _____

Did the patient develop hepatitis?

Did the patient die from measles or complications (including secondary infection) associated with measles?
If yes, date of death: __/__/____

*LABORATORY (Please submit copies of all labs to DIDE)

Y N U

Was laboratory testing done for measles? Lab name: _____
Lab Address: _____ Phone number: _____ Fax number: _____

Were IgM testing performed? If yes: Date IgM specimen taken: __/__/____
Result: Positive Negative Indeterminate Pending Unknown Not done

Was IgG acute/convalescent testing performed? If yes: Date acute specimen taken: __/__/____
Date convalescent specimen taken: __/__/____
Result: Significant rise in IgG No significant rise in IgG Indeterminate Pending Unknown Not done

Was other laboratory testing done? If yes, specify other test: _____
Date of other test: __/__/____ Other lab test result: _____

Were clinical specimens sent to CDC for genotyping? If yes, date sent: __/__/____ Specimen type: _____
 Was the measles virus genotype sequenced? Y N U
 If yes, identify the genotype: A B2 B3 C1 C2 D10 D2 D2 D3 D4 D5 D6 D7
 D8 D9 G2 G3 H1 H2 Unknown Other (specify): _____

VACCINE INFORMATION

*Did the patient receive a measles-containing vaccine? Y N U If yes: Number of doses received BEFORE 1st birthday? _____
 Number of doses received ON or AFTER 1st birthday? _____

If not vaccinated, what was the reason?

Lab evidence of previous disease MD diagnosis of previous disease Medical contraindication Parental Refusal
 Philosophical objection Religious exemption Under age for vaccination Unknown Other (specify) _____

If vaccinated BEFORE 1st birthday, but no doses give ON or AFTER 1st birthday, what is the reason?

Born outside of US Lab evidence of previous disease MD diagnosis of previous disease Medical contraindication
 Never offered vaccine Parent/patient forgot to vaccinate Parent/patient refusal Parent/patient report of disease
 Philosophical objection Religious exemption Under age for vaccination Unknown Other: _____

If patient received one dose ON or AFTER 1st birthday, but never received second dose, what is the reason?

Born outside of US Lab evidence of previous disease MD diagnosis of previous disease Medical contraindication
 Never offered vaccine Parent/patient forgot to vaccinate Parent/patient refusal Parent/patient report of disease
 Philosophical objection Religious exemption Under age for vaccination Unknown Other: _____

VACCINATION RECORD

Date received: __/__/____ Anatomical site: _____	Given by: Last Name: _____
Vaccine administered: _____ Vaccine ID: _____	First Name: _____ Provider ID: _____
Manufacturer: _____ Organization ID: _____	Organization Name: _____
Lot #: _____ Expiration Date: __/__/____	Organization ID: _____

Date received: __/__/____ Anatomical site: _____	Given by: Last Name: _____
Vaccine administered: _____ Vaccine ID: _____	First Name: _____ Provider ID: _____
Manufacturer: _____ Organization ID: _____	Organization Name: _____
Lot #: _____ Expiration Date: __/__/____	Organization ID: _____

Date received: __/__/____ Anatomical site: _____	Given by: Last Name: _____
Vaccine administered: _____ Vaccine ID: _____	First Name: _____ Provider ID: _____
Manufacturer: _____ Organization ID: _____	Organization Name: _____
Lot #: _____ Expiration Date: __/__/____	Organization ID: _____

EPIDEMIOLOGIC

Y N U
 Does this patient reside in the US?
 *Is this case epi-linked to another confirmed or probable case?
 Were age and setting verified?
 * Is this case part of an outbreak of 3 or more cases? If yes, name of outbreak? _____
 Source of infection (i.e. person ID, country, etc.): _____
 Did rash onset occur within 18 days of entering the US, following any travel or living outside the USA?
 Is this case traceable (linked) to an international import?

Transmission Setting (where did this case acquire measles?):

<input type="checkbox"/> Athletics	<input type="checkbox"/> College	<input type="checkbox"/> Community	<input type="checkbox"/> Correctional facility
<input type="checkbox"/> Daycare	<input type="checkbox"/> Doctor's office	<input type="checkbox"/> Home	<input type="checkbox"/> Hospital ER
<input type="checkbox"/> Hospital outpatient clinic	<input type="checkbox"/> Hospital ward	<input type="checkbox"/> International travel	<input type="checkbox"/> Military
<input type="checkbox"/> Place of worship	<input type="checkbox"/> School	<input type="checkbox"/> Work	<input type="checkbox"/> Other <input type="checkbox"/> Unknown

Where was the disease acquired? Indigenous, within jurisdiction Out of country Out of jurisdiction, from another jurisdiction
 Out of state Unknown

Confirmation method: Clinical diagnosis (not lab confirmed) Epidemiologically linked Lab confirmed

PUBLIC HEALTH ACTIONS/NOTES

Y N U Lost to follow-up
 Disease education and prevention information provided to patient and/or family/guardian
 If yes, date: __/__/____

Activity History for 18 Days before Rash Onset and 7 Days After Rash Onset

Day	Activity
-18	
-17	
-16	
-15	
-14	
-13	
-12	
-11	
-10	
-9	
-8	
-7	
-6	
-5	
-4	
-3	
-2	
-1	
0 (rash onset)	
1	
2	
3	
4	
5	
6	
7	

Public Health Action Taken

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