

Measles

COUNTY

FOR STATE USE ONLY

#

Region X _____

Case report ___/___/___

Interstate ___/___/___

Preventable yes no

lab confirmed

epi-linked

clinical Dx

FOR STATE USE ONLY

out-of-state index international index

Date investigation initiated: ___/___/___

indigenous out-of state spread international spread

time: ___:___ am pm

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

Lab Infection Control Practitioner

Physician _____

Name _____

Phone _____

Date ___/___/___ Time ___:___ am pm
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX female male

DATE OF BIRTH ___/___/___

or, if unknown, AGE _____

HISPANIC yes no unknown

RACE

White American Indian

Black Asian/Pacific Islander

unknown refused to answer

other _____

Worksites/school/day care center _____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

PRODROME yes no unknown

If yes, ONSET DATE (first s/s) ___/___/___
m d y

check all that apply

cough

coryza

conjunctivitis

photophobia

Koplik spots

fever - date noted ___/___/___

maximum temp. recorded ___¹/₂

Comments _____

RASH yes no

If yes, ONSET DATE ___/___/___

Duration ___ days

Number locations in order of rash appearance:

___ face/neck/forehead

___ trunk

___ extremities

___ _____

Type of rash:

maculopapular

vesicular

petechial

Pruritic yes no

Were antibiotics used in the 7 days before rash

onset? yes no unknown

if yes, specify: _____

OTHER CLINICAL FINDINGS

lymphadenopathy

cervical

postauricular

suboccipital

diarrhea

otitis media

pneumonia

encephalitis

Hospitalized yes no

if yes, where _____

adm. ___/___/___ Length of stay ___ days
m d y

Died yes no ___/___/___
m d y

LABORATORY DATA

Lab name _____

Virus Isolation

Throat swab: ___/___/___ pos neg not done unk
m d y

Urine: ___/___/___
m d y

PCR

Throat swab: ___/___/___ pos neg not done unk
m d y

Urine: ___/___/___
m d y

Serology

Date IgM specimen taken ___/___/___ pos neg not done unk
m d y

Date IgG Acute specimen taken ___/___/___
m d y

Date IgG Convalescent specimen taken ___/___/___
m d y

Tests for other agents?

yes no unknown

If yes, specify and give details (date, type of test, results, etc.).

rubella

strep.

mononucleosis

parvovirus

EPI-LINKAGE

During the exposure period, was the patient

associated with a known outbreak

a close contact of a **confirmed** or **presumptive** case

was source case reported? yes not yet

Is the patient aware of anyone with a similar illness? yes no

if yes to any question, give names, contact information, and other relevant details:



IMMUNIZATION HISTORY

Vaccine received in past yes no unknown if yes, complete table:

Vaccine	Date	Provider/Phone	Verified	
			yes	no
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>

if not vaccinated, why not? If available, provide details.

age less than 15 months

medical exemption

religious objection

"forgot"

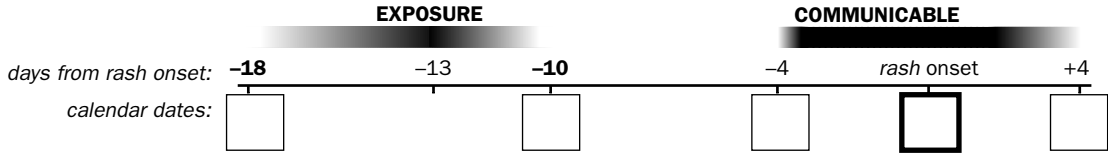
cost too much

inconvenience

concurrent illness

INFECTION TIMELINE

Enter onset date of rash in heavy box. Count forwards and backwards to figure probable exposure and communicable periods.



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case was already epi-linked.

Specify details of any potential exposures, giving relevant dates, locations, contact persons, phone numbers, etc. Attach additional sheets if necessary.

Identify possible exposures in the 10-18 days prior to rash onset:

- contact of **suspect** case
- visit to doctor's office/clinic
- visit to emergency room
- travel outside Oregon
- _____
- no exposure identified
- patient could not be interviewed

CASE-CONTACT MANAGEMENT/FOLLOW-UP

Case education provided? yes no unknown if yes, date ___/___/___

Evaluate the immune status of household and other close contacts. Attach additional sheets if necessary.

Name	Relation to Case	Age	Measles Hx			Vaccination Hx			Dates	Reported by	Education Provided		
			yes	no	unk	yes	no	unk			yes	no	unk
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Were control measures initiated within 24 hours? yes no

Investigate likely sites of transmission. For each site, specify if not applicable (NA), investigated but no other follow-up required (no F/U), or, more follow-up required (F/U). If additional F/U is indicated, provide details at right.

- NA no F/U F/U
- daycare/babysitting/preschool
 - school/college
 - worksite
 - visit to E.R./urgent care clinic
 - visit to doctor's office/clinic
 - EMT contact
 - indoor public gatherings (church, etc.)
 - travel outside Oregon
 - _____

Relevant details include dates, locations, facilities, names and phone numbers of contact persons, the nature of the exposure, etc. Summarize results of the follow-up (number of contacts identified, at risk, vaccinated, etc.). Attach additional sheets if necessary.

ADMINISTRATION

Date and time case report sent to OHS: ___/___/___ ___ am pm

Completed by _____ Date Completed _____ Phone _____ Investigation sent to OHS on ___/___/___