Measles

ORPHEUS ID

☐ confirmed
☐ presumptive
☐ suspect
☐ no case

☐ U.S. resident
Exposure venue
☐ in Oregon ☐ Elsewhere in U.S
☐ outside U.S. ☐ Indeterminate

Name _____ County_____
LAST, first, initials (a.k.a.)

Address _____
Street City

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

E-mail _____

Special housing
☐ Nursing home/ Asst Living
☐ Homeless
☐ Prison/jail
☐ Foster home
☐ Hospital
☐ Nursing home
☐ Other institution
☐ Drug treatment/ shelter
☐ Women's shelter
☐ YES house
☐ Homeless shelter
☐ Job Corps
☐ Treatment center
☐ Chemawa Indian School
☐ Pacific Univ.
☐ No address on file

ALTERNATE CONTACT

Name _____ Phone(s)_____
LAST, first, initials home (H), work (W), cell (C), mes-

DEMOGRAPHICS

DOB ____/____/____ if DOB unknown, AGE _____ Sex ☐ Female ☐ Male Preg ☐ Y ☐ N ☐ UNK
m d y

Language _____ Country of birth _____ ☐ refugee

Worksites/school/day care center _____ Occupation/grade_____

Amer Indian/ Alaska Native
☐ American Indian
☐ Alaska Native
☐ Canadian Inuit, Metis First Nation
☐ Indigenous Mexican Central American South American

HISPANIC or Latino/a
☐ Hispanic or Latino/a Central American
☐ Hispanic or Latino/a Mexican
☐ Hispanic or Latino/a South American
☐ Other Hispanic or Latino/a

ASIAN
☐ Asian Indian
☐ Chinese
☐ Filipino/a
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ South Asian
☐ Vietnamese
☐ Other Asian

Native Hawaiian/ Pacific Islander
☐ Guamanian or Chamorro
☐ Micronesian
☐ Native Hawaiian
☐ Samoan
☐ Tongan
☐ Other Pacific Islander

Black or African American
☐ African American
☐ African (Black)
☐ Caribbean (Black)
☐ Other Black

Middle Eastern Northern African
☐ Northern African
☐ Middle Eastern

White
☐ Eastern European
☐ Slavic
☐ Western European
☐ Other White

Other Categories
☐ Other (please list)
_____
☐ Don't know/Unknown
☐ Don't want to answer/ Decline

_____

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
_____
_____
_____

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
_____
_____
_____

☐ Ok to contact patient (only list once)
Local epi_name_____
Date report received by LHD ____/____/____LHD completion date ____/____/____

CASE'S NAME

BASIS OF DIAGNOSIS - MEASLES

CLINICAL DATA

Prodome ____/____/_____ Rash onset ____/____/_____

check all that apply

y	n	u	r	
☐	☐	☐	☐	prodome
☐	☐	☐	☐	any cough
☐	☐	☐	☐	coryza
☐	☐	☐	☐	photophobia
☐	☐	☐	☐	Koplik spots
☐	☐	☐	☐	fever, maximum temp. recorded _____
☐	☐	☐	☐	conjunctivitis
☐	☐	☐	☐	rash Duration _____ days
☐	☐	☐	☐	antibiotics used in the 7 days before rash

Locations of rash

☐ face/neck/forehead ☐ trunk
☐ extremities ☐ inside of mouth
☐ other _____

Type of rash

☐ maculopapular ☐ vesicular
☐ petechial ☐ other
☐ other _____

☐ ☐ ☐ ☐ pruritic

OTHER CLINICAL FINDINGS

☐ lymphadenopathy (choose from list)
☐ cervical ☐ supraclavicular
☐ postauricular ☐ axillary
☐ suboccipital ☐ submental
☐ other (specify) _____

check all that apply

y	n	u	r	
☐	☐	☐	☐	diarrhea
☐	☐	☐	☐	otitis media
☐	☐	☐	☐	pneumonia
☐	☐	☐	☐	encephalitis

NOTES

HOSPITALIZATION

Deceased: ☐ yes ☐ no date of death ____/____/____

Cause: _____
☐ related to disease ☐ unrelated to disease ☐ unk

Hospitalized: ☐ yes ☐ no ☐ unk
Hospital Name _____

admit date ____/____/____ ☐ ICU
discharge date ____/____/____

Hospital Name _____
admit date ____/____/____ ☐ ICU
discharge date ____/____/____

CASE'S NAME

BASIS OF DIAGNOSIS, CONT.

LABORATORY DATA

Laboratory Name _____
Collection date ____/____/____ Result date ____/____/____

Specimen type:
☐ serum ☐ NP swab ☐ throat swab/oropharyngeal swab ☐ urine
Test type: if serum - ☐ IgG acute ☐ IgG convalescent ☐ IgM
if throat swab/oropharyngeal swab, NP swab or urine ☐ Culture ☐ PCR
Result: ☐ Positive ☐ Negative

Laboratory Name _____
Collection date ____/____/____ Result date ____/____/____

Specimen type:
☐ serum ☐ NP swab ☐ throat swab/oropharyngeal swab ☐ urine
Test type: if serum - ☐ IgG acute ☐ IgG convalescent ☐ IgM
if throat swab/oropharyngeal swab, NP swab or urine ☐ Culture ☐ PCR
Result: ☐ Positive ☐ Negative

LABORATORY DATA

Laboratory Name _____
Collection date ____/____/____ Result date ____/____/____

Specimen type:
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Laboratory Name _____
Collection date ____/____/____ Result date ____/____/____

Specimen type:
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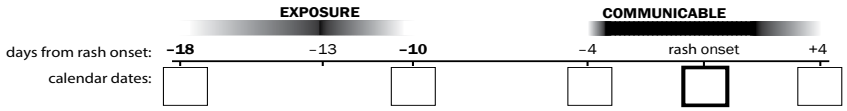
Test type: if serum - ☐ IgG acute ☐ IgG convalescent ☐ IgM
if throat swab/oropharyngeal swab, NP swab or urine ☐ Culture ☐ PCR
Result: ☐ Positive ☐ Negative

INFECTION TIMELINE

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



Interviewed ☐ yes ☐ no Interview date(s) _____ Interviewed by _____

Who ☐ patient ☐provider ☐ parent ☐ other

Reason not interviewed (choose one)
☐ not indicated ☐ unable to reach ☐ out of jursdiction ☐ deceased
☐ refused ☐ physician interview ☐ medical record review

y n u r
☐ ☐ ☐ ☐ *Travel outside the home area*
When _____
*Where*_____
☐ ☐ ☐ ☐ contact of suspect case
☐ ☐ ☐ ☐ prior vaccination
☐ ☐ ☐ ☐ places where exposed (check boxes to right)
☐ ☐ ☐ ☐ other risk, specify in notes

Places where exposed
☐ daycare ☐ work ☐ other
☐ school ☐ college ☐ unknown
☐ doctor's office ☐ military
☐ hospital ward ☐ correctional facility
☐ hospital ER ☐ place of worship
☐ hosp.outpatient clinic ☐ international travel
☐ home

FOLLOW-UP

y n u r
☐ ☐ ☐ ☐ contact with infants
☐ ☐ ☐ ☐ contact with pregnant women
☐ ☐ ☐ ☐ contact with immunocompromised patients

Settings where the case may have exposed others during infectious period
☐ daycare ☐ hospital ward ☐ >1 setting outside household ☐ college ☐ place of worship
☐ school ☐ hospital ER ☐ work ☐ military ☐ international travel
☐ doctor's office ☐ hosp.outpatient clinic ☐ unknown ☐ correctional facility ☐ other
☐ no documented spread

EPI-LINKAGE

y n u
☐ ☐ ☐ associated with known outbreak
☐ ☐ ☐ close contact of another case
Nature
☐ coworker ☐ daycare
☐ friend ☐ household
☐ infant ☐ unborn baby
☐ ☐ ☐ has case been reported

Epi-link ☐ household ☐ sporadic ☐ outbreak

Exposure type
☐ single ☐ multiple ☐ unknown
Exposure date and time ___/___/___ _____
Outbreak ID_____
Generation ☐ 1 ☐ 2

CASE'S NAME

IMMUNIZATION HISTORY

Up to date for measles ☐ yes ☐ no ☐ unk

Vaccine *Date* *Source choose one:* ALERT / Provider / Verbal (Shot card) / Verbal (not verified)

_____ ___/___/___ _____
_____ ___/___/___ _____
_____ ___/___/___ _____
_____ ___/___/___ _____
_____ ___/___/___ _____

If you have access to ALERT, please print the vaccination history and staple to this form.

Vaccinated: ☐ yes ☐ no ☐ unk
if not vaccinated, why not?
☐ Religious exemption
☐ Medical contraindication
☐ Philosophical exemption
☐ Previous culture/MD confirmed
☐ Parental/patient refusal
☐ Too young _____
☐ Forgot
☐ Inconvenience
☐ Too expensive _____
☐ Concurrent illness
☐ Parent/patient unaware
☐ Vaccination records incomplete (unavailable)
☐ Other
☐ Unknown

CONTACT MANAGEMENT

Add additional sheets as necessary	Contact 1	Contact 2
Name (First, middle, last, no initials please)		
Phone number		
Address (street, city)		
Address, (county, zip)		
Date of birth/ age mm/dd/yyyy or years of age	___/___/___	___/___/___
High risk	☐ Yes ☐No	☐ Yes ☐No
Sex	☐ Male ☐Female	☐ Male ☐Female
Pregnant	☐ Yes ☐No *if yes*, due date ___/___/___	☐ Yes ☐No *if yes*, due date ___/___/__
Relation to case (coworker, daycare, friend, household, infant, unborn baby)		
Occupation		
Sick	☐ Yes ☐No *if yes*, onset date ___/___/__	☐ Yes ☐No *if yes*, onset date ___/___/__
First exposure / Last exposure	First exposure ___/___/___ Last exposure ___/___/___	First exposure ___/___/___ Last exposure ___/___/___
Location of exposure		
Prophy recommended?	☐ Yes ☐No *if yes*, date ___/___/___	☐ Yes ☐No *if yes*, date ___/___/___
Education provided?	☐ Yes ☐No *if yes*, date ___/___/___	☐ Yes ☐No *if yes*, date ___/___/___
MMR 1 mm/dd/yyyy	___/___/___	___/___/___
MMR 2 mm/dd/yyyy	___/___/___	___/___/___
IG (date)	___/___/___	___/___/___
History of prior disease (circle one)	☐ Yes ☐No ☐ Unk	☐ Yes ☐No ☐ Unk
Up-to-date for disease (circle one)	☐ Yes ☐No ☐ Unk	☐ Yes ☐No ☐ Unk
Vax count		
Specimen (date), test type, result		
Lab name		

ADMINISTRATION SEPTEMBER 2018

Case report sent to OHA on ___/___/___` **Investigation sent to OHA on** ___/___/___

Completed by _____ **Date** _____ **Phone** _____