



Measles (Rubeola)

PATIENT DEMOGRAPHICS

Name (last, first): _____
 Address: _____
 City/State/Zip: _____
 Phone (home): _____ Phone (work): _____
 Occupation/grade: _____ Employer/School: _____
 Alternate contact: Parent/Guardian Spouse Other
 Name: _____ Phone: _____

*Birth date: __/__/____ Age: ____
 *Gender: Male Female Unk
 *Ethnicity: Not Hispanic or Latino
 Hispanic or Latino Unk
 *Race: White Black/Afr. Amer.
 (Mark all that apply) Asian Am. Ind/AK Native
 Native HI/Other PI Unk

INVESTIGATION SUMMARY

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

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

<p>Symptoms Did the patient have any of the following: Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coryza (runny nose) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Conjunctivitis</p>	<p>Complications Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Croup <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Otitis media <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pneumonia</p>	<p>Y N U <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): _____</p>
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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: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: // _____	Given by: Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
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Date received: // _____ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: // _____	Given by: Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
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Date received: // _____ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: // _____	Given by: Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____
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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?):

Athletics College Community Correctional facility
 Daycare Doctor's office Home Hospital ER
 Hospital outpatient clinic Hospital ward International travel Military
 Place of worship School Work Other 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

