WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

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: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: / / _____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ 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**
☐ ☐ ☐ Did the patient have a fever? If yes: Fever onset date: _ /_ /_____ Highest measured temperature_____° ☐ Celsius ☐ Fahrenheit

Symptoms
Did the patient have any of the following:

Y	N	U	
☐	☐	☐	Cough
☐	☐	☐	Coryza (runny nose)
☐	☐	☐	Conjunctivitis

Complications

Y	N	U		Y	N	U	
☐	☐	☐	Croup	☐	☐	☐	Encephalitis
☐	☐	☐	Otitis media	☐	☐	☐	Thrombocytopenia
☐	☐	☐	Diarrhea	☐	☐	☐	Other (specify): _____
☐	☐	☐	Pneumonia				_____

☐ ☐ ☐ 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: __________________
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: __________________
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: __________________

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

*Contact Tracing Sheet								
Name/Contact Information (including guardian information for minors)	Contact or source?	Date of Birth (mm/dd/yyyy)	Sex	Relationship to case?	Number of doses of measles-containing vaccine?	Date(s) of vaccination (mm/dd/yyyy)	Is this a case? (Y/N)	Rash onset date? **(mm/dd/yyyy)**

Number of contacts in any setting recommended PEP: _____

Y=Yes N=No U=Unknown

*required surveillance indicator