Sample Measles Outbreak Case Investigation and Follow-up Form

Form Completed by_____
Date Form Completed _____
Public Health Unit_____
Case ID Number: _____

Final Status: ❑ Confirmed ❑ Probable ❑ Ruled out
Index Case: ❑ Yes ❑No ❑Unknown
Secondary Case: ❑ Yes ❑No ❑Unknown

Case Identification

Last Name: _____
Date of Birth: YYYY/MM/DD_____
Age at Onset: _____
Address: _____
City/Town: _____
Postal Code: _____
Phone Number: __ (____) _____
❑ Home ❑ Work ❑ Cell ❑ Other
Parent/Guardian/Next of Kin: _____

First Name: _____
Sex: ❑ Male ❑ Female Other ❑

Province: _____
Family Physician: _____
Phone Number: __(____)_____
E-mail:_____

Clinical Information

Symptoms:

❑Maculopapular rash
Date of onset:_____/_____/_____ Duration:_____days
Where did rash start? □Face □Trunk □ Extremities
Is rash generalized? □ Yes □ No □ Unknown

❑Fever:
Date of onset:_____/_____/_____ Max Temp:_____ºC

❑ Oral ❑ Rectal ❑ Axillary

❑Coryza
❑Conjunctivitis
❑Cough
❑Pharyngitis
❑Koplik's spots
❑Light Sensitivity

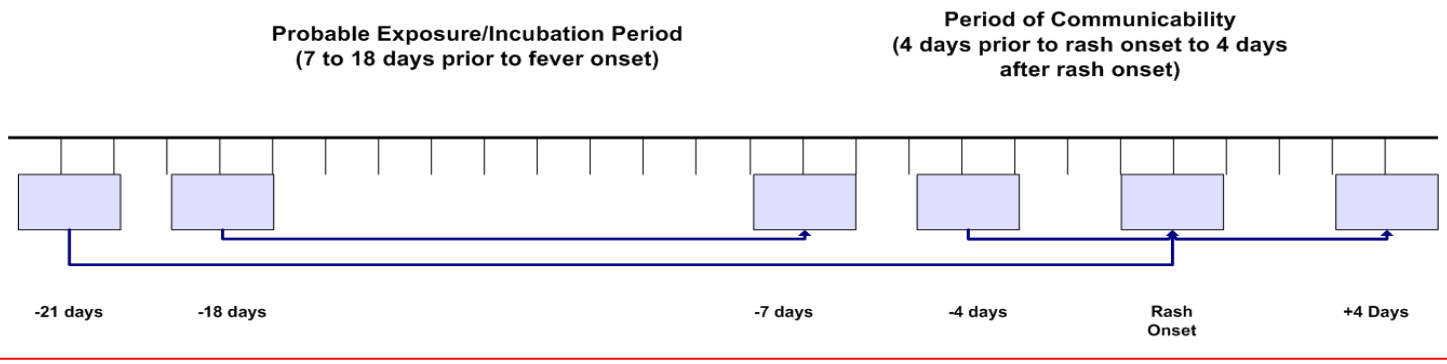
❑Other

Hospitalization: ❑ Yes ❑ No ❑Unknown
If yes, Name of Hospital: _____
Date admitted: _____ Date discharged: _____

Attended Out-patient Clinic? ❑ Yes ❑ No ❑Unknown
If yes, Name of Clinic: _____ Date of visit: _____

Clinical Outcome:
❑ Recovered ❑ without residual effects ❑with residual effects
❑ Residual effects:
❑ Otitis Media ❑Pneumoniae ❑Encephalitis ❑Meningitis ❑ Bronchitis ❑ Diarrhea ❑ Other_____
❑Fatal
Date of Death_____
Death Due to Measles/Complications: ❑Yes ❑No
❑Unknown

Calculation of Incubation and Communicability Period



History of Immunization

History of measles disease: ❑ Yes ❑ No ❑Unknown
Received measles-containing vaccine in the past: ❑ Yes ❑No ❑Unknown
If no immunization, specify reason: _____

Vaccine Name	Date Received (YYYY/MM/DD)	Age (Yrs)	Province/Territory/ Or Country	Lot Number (if known)
1.				
2.				
3.				

Laboratory Information

	Sample 1	**Sample 2**	**Sample 3**	**Sample 4**
Type of Sample	❑ Nasopharyngeal aspirate/swab ❑ Throat swab ❑ Serum ❑ Urine ❑ Other:_____	❑ Nasopharyngeal aspirate/swab ❑ Throat swab ❑ Serum ❑ Urine ❑ Other:_____	❑ Nasopharyngeal aspirate/swab ❑ Throat swab ❑ Serum ❑ Urine ❑ Other:_____	❑ Nasopharyngeal aspirate/swab ❑ Throat swab ❑ Serum ❑ Urine ❑ Other:_____
Identification #				
Date taken	**Day/Month/Year**	**Day/Month/Year**	**Day/Month/Year**	**Day/Month/Year**
Date Sent				
FOR LABORATORY USE				
Date Received	**Day/Month/Year**	**Day/Month/Year**	**Day/Month/Year**	**Day/Month/Year**
Id # in laboratory				
Type of test	❑ IgM EIA capture ❑ IgM EIA indirect ❑ IgG EIA ❑ Viral isolation ❑ PCR ❑ Other test	❑ IgM EIA capture ❑ IgM EIA indirect ❑ IgG EIA ❑ Viral isolation ❑ PCR ❑ Other test	❑ IgM EIA capture ❑ IgM EIA indirect ❑ IgG EIA ❑ Viral isolation ❑ PCR ❑ Other test	❑ IgM EIA capture ❑ IgM EIA indirect ❑ IgG EIA ❑ Viral isolation ❑ PCR ❑ Other test
Results	❑ Positive ❑ Negative ❑ Indeterminate ❑ Inadequate sample ❑ Not processed	❑ Positive ❑Negative ❑Indeterminate ❑Inadequate sample ❑ Not processed	❑ Positive ❑ Negative ❑ Indeterminate ❑ Inadequate sample ❑ Not processed	❑ Positive ❑ Negative ❑ Indeterminate ❑ Inadequate sample ❑ Not processed
Results dates	**Day/Month/Year**	**Day/Month/Year**	**Day/Month/Year**	**Day/Month/Year**
comment				

Exposure Information:

Have you had contact with anyone who was told they have measles: ❑ Yes ❑ No
If yes, Name of Person: _____

Social activities in the 7 days before case developed symptoms

Social Activities in the past 7 days	Date(s) (YYYY/MM/DD)	Activity Details
❑ Used public transit		
❑ Visited or volunteered at a hospital		
❑ Attended church/religious function		
❑ Attended family gathering		
❑ Attended meeting or conference		
❑ Attended concert, theatre or sporting event		

❑ Participated in shopping event		
❑ Participated in recreational activity		
❑ Dined at coffee shop/cafeteria/food court		
❑ Dined at restaurant		
❑ Patronised bar or night club		
❑ Other activities		

Travel History in the past 7 days:	Date(s) (YYYY/MM/DD)	Location
❑ Domestic		
❑ International		

Occupational Information
Occupation: _____Name of Employer: _____

Day Care/School/Educational Institution
Do you attend a day care, school or post-secondary institution? ❑ Yes ❑ No
If *YES*, Name of School/Institution: _____Grade/Level/Year: _____
Timetable (Please attach if available):_____

Living Arrangements
What type of residence do you live in?
❑ House ❑ Apartment ❑ University residence ❑ Hotel/Motel ❑ Group Home or Long-Term Care Facility ❑ Other (please specify)_____
Do you live, room or share accommodation with anyone? ❑ Yes ❑ No
If *YES*, with how many people? _____
Do you receive home care? ❑ Yes ❑ No

Close Contact Information
Please list all close contacts, including your spouse, partner, siblings, children, family members, roommates and other people you live with

Contact Name (Surname, Given Name)	**Contact Phone Number**	**Relationship**	**Date of Birth** (YYYY/MM/DD) **or Age**	**Immunization Status Not Immunized (0) Immunized - 1 Dose (1) Immunized - 2 Dose (2) History of Measles (8)**	**Occupation**

Comments/Notes:

Classification

Measles-laboratory confirmed ❑
Measles probable case ❑
Discarded ❑
Basis for classification: ❑ Laboratory results ❑ Epidemiological link ❑ Clinical Presentation
Investigator: _____ Institution: _____ Date:_____