Tennessee Department of Health

Measles Case Report

Draft, Revised: 09/2010

Please fill out all three pages of this form as complete as possible. Anything that appears in **red** is not available for data entry into NEDSS. However, you may find those fields helpful in your investigation. Notify Central Office Immunization Epidemiologist or Medical Director about the case.

DEMOGRAPHICS

CASE ID#:_____

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____

Reported Age: _____ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Phone - Home: _____ **Work:** _____ **Cell:** _____

Ethnicity: □ Hispanic □ Not Hispanic

Race: □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Other (_____)

Employer/School/Daycare: _____ **Occupation:** _____

ALTERNATE CONTACT INFORMATION

Last Name: _____ **First:**_____ **Relationship:** □ Parent □ Spouse □ Household Member □ Friend □ Other _____

Phone #:_____

INVESTIGATION SUMMARY

Jurisdiction: □ East Tennessee □ Mid-Cumberland □ Northeast □ South Central □ Southeast □ West Tennessee □ Upper Cumberland □ Nashville/Davidson □ Chattanooga/Hamilton □ Knoxville/Knox □ Jackson/Madison □ Memphis/Shelby □ Sullivan □ Out of Tennessee □ Unassigned

INVESTIGATION SUMMARY

Investigation Start Date: _____/_____/_____

Investigation Status: □ Open □ Closed

Investigator: _____

Date Assigned to Investigation: _____/_____/_____

Physician: _____

Physician's Phone: _____

REPORTING SOURCE

Date of Report: _____/_____/_____

Reporting Source: _____

Earliest Date Reported to County: _____/_____/_____

Earliest Date Reported to State: _____/_____/_____

Reporter: _____

CLINICAL INFORMATION

HOSPITAL INFORMATION

Was the patient hospitalized for this illness? □ Yes □ No □ Unknown

Hospital: _____

Admission Date:____/____/_____ **Discharge Date:** ____/____/_____

Diagnosis Date: ____/____/_____ **Illness Onset Date:** ____/____/____

Airborne isolation/infection control recommendations implemented? □ Yes □ No □ Unknown **If yes, describe**:_____

_____

CONDITION

Did patient have a rash? □ Yes □ No □ Unknown

Rash onset Date:____/____/_____

Duration:____**days**

Was the rash generalized? □ Yes □ No □ Unknown

Did patient have a fever? □ Yes □ No □ Unknown

Highest Temperature:_____

SYMPTOMS

Did patient have any of the following symptoms?
(Check all that apply)

□ **Cough**

□ **Coryza (runny nose)**

□ **Conjunctivitis**

COMPLICATIONS

(Check all that apply)

□ **Croup** □ **Otitis media** □ **Diarrhea** □ **Pneumonia** □ **Encephalitis**

□ **Thrombocytopenia** □ **If other complications, specify**_____

Did the patient develop hepatitis? □ Yes □ No □ Unknown

Did the patient die from measles or complications (including secondary infection) associated with measles? □ Yes □ No □ Unknown

COMMENTS

_____

_____

_____

_____

_____

LABORATORY

CASE ID#:_____

Was laboratory testing done for measles? □ Yes □ No □ Unknown *(If yes, complete the table below.)*

	IgM Serum	Acute IgG Serum	Convalescent IgG Serum	Other Lab Tests
Was testing performed?	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown
Name of Laboratory				
Date Specimen Taken				
Result of Test	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ No significant rise in IgG □ Significant rise in IgG □ Pending □ Indeterminate □ Unknown		□ Negative □ Positive □ Pending □ Indeterminate □ Unknown

Were the clinical specimens sent to CDC for genotyping (molecular typing)? □ Yes □ No □ Unknown

Date sent for genotyping: _____/_____/_____

Specimen Type:_____

Was the (measles) virus genotype sequenced? □ Yes □ No □ Unknown

If yes, identify the genotype: □A □B2 □B3 □C1 □C2 □D2 □D3 □D4 □D5 □D6 □D7 □D8 □D9 □D10 □G2 □G3 □H1 □H2 □Unknown □Other:_____

Specimen type:_____

VACCINATION

Did the patient receive measles containing vaccine? □ Yes □ No □ Unknown

Number of doses received BEFORE 1st birthday: _____ **Number of doses received ON or AFTER 1st birthday:** _____

If vaccinated BEFORE first birthday, but not doses given ON or AFTER first birthday, what is the reason?_____ (enter # from below)

If patient received one dose ON or AFTER first birthday, but never received a second dose after the first birthday, what is the reason? _____ (enter # from below)

Reason:

1- Born outside of US
2- Laboratory evidence of previous disease
3- MD diagnosis of previous disease
4- Medical Contraindication
5- Parent/Patient forgot to vaccinate
6- Parent/Patient refusal
7- Parent/Patient report of disease
8- Philosophical objection
9- Religious exemption
10- Underage for vaccination
11- Unknown

Dates of each MMR vaccination: **1** ____/____/_____ **2** ____/____/_____ □ Dates Unknown

EPIDEMIOLOGIC INFORMATION

Does this patient reside in the USA?: □ Yes □ No □ Unknown

Length of time in the United States (in years): _____ **Country of birth:** _____

Is this case epi-linked to another confirmed or probable case? □ Yes □ No □ Unknown

What was the transmission setting (use number from choices)?_____

1 - Athletics 2 - College 3 - Community 4 - Correctional facility 5 - Day Care 6 - Doctor's office
7 - Home 8 - Hospital ER 9 - Hospital outpatient clinic 10 - Hospital ward 11 - International travel 12 - Military
13 - Church 14 - School 15 - Unknown 16 - Work 17 - Other

Were age and setting verified? □ Yes □ No □ Unknown

COMMENTS

EPIDEMIOLOGIC INFORMATION (CONTINUED)

CASE ID#:_____

Is this case part of an outbreak of 3 or more cases?: □ Yes □ No □ Unknown ***If yes*, outbreak name:** _____

Source of infection (i.e. person ID, country, …):_____

Did rash onset occur within 18 days of entering the US, following any travel or living outside the US? □ Yes □ No □ Unknown

Is this case traceable (linked) to an international import? □ Yes □ No □ Unknown

Where was the disease acquired?: □ Indigenous (within jurisdiction) □ Out of country □ Out of state □ Out of jurisdiction □ Unknown

Imported Country: _____ **Imported State:** _____

Imported City: _____ **Imported County:** _____

CONTACT INFORMATION

Index Case Name:	**Index Case #:**

Contact Name	Date of Birth	Relationship To case	Date of exposure	# of Vaccines Doses	Date of Last Vaccine	Phone Number

Confirmation Method: □ Clinical Diagnosis □ Epidemiologically-linked □ Lab Confirmed □ Other (_____)

Case Status: □ Confirmed □ Suspect □ Probable

COMMENTS

_____

_____

_____

_____

FOR ADMINISTRATIVE USE ONLY:

Date of Interview: ____/____/_____

Interviewer's Name: _____

Other Notes: _____

Was the case entered into NEDSS? □ Yes □ No □ Unknown

Date entered into NEDSS: ____/____/_____

Data Entry Person's Name: _____