

**MEASLES CASE INVESTIGATION FORM**

EPID NUMBER: \_\_\_\_\_

Name of person completing form: \_\_\_\_\_ Signature: \_\_\_\_\_

Sources of Data: Caregiver ☐ Clinician ☐ Medical records ☐ No data obtained ☐

Name of Health Facility attended: \_\_\_\_\_ Name of attending clinician: \_\_\_\_\_

Health Facility street address: \_\_\_\_\_

Contact number: \_\_\_\_\_

**PATIENT DETAILS**Full name: \_\_\_\_\_ Gender: M ☐ F ☐ Unknown ☐Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ If DOB unknown Age: \_\_\_\_ Unit: Days ☐ Wks ☐ Months ☐ Yrs ☐; DOB and Age Unk ☐

Street address: \_\_\_\_\_

Town/ City: \_\_\_\_\_ Province: \_\_\_\_\_ Contact Number(s): \_\_\_\_\_

**CURRENT PRESENTATION**Presenting symptoms/signs (Tick all applicable Boxes): Rash ☐ Fever ☐ Conjunctivitis ☐ Cough ☐Coryza/Rhinitis/runny nose ☐ Other (Specify) \_\_\_\_\_

Date of onset of rash: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Presentation at the health facility: \_\_\_\_/\_\_\_\_/\_\_\_\_

Complications (Tick where applicable): None ☐ Pneumonia ☐ Otitis Media ☐ Diarrhoea ☐ Febrile seizures ☐Laryngotracheobronchitis (Croup) ☐ Corneal Ulceration ☐ Blindness ☐ Encephalitis ☐Clinical Management: Vitamin A given: Y ☐ N ☐Final outcome (Tick where applicable): Patient admitted to Hospital: Y ☐ N ☐ Patient Died: Y ☐ N ☐Specimens Collected (Tick where applicable): Blood/Serum ☐ Urine ☐ Nasopharyngeal/Saliva ☐Dried Blood Spot ☐ Date of specimen collection: \_\_\_\_/\_\_\_\_/\_\_\_\_**MEDICAL AND CONTACT HISTORY**History of contact with a suspected measles case in the past 7 to 28 days: Y ☐ N ☐ Unknown ☐History of contact with a laboratory confirmed measles case in the past 7 to 28 days: Y ☐ N ☐ Unknown ☐History of travel in the past 7 to 28 days: Y ☐ N ☐; if yes, name of place or country travelled to \_\_\_\_\_History of previous visit or admission to a healthcare facility in the past 7 to 28 days: Y ☐ N ☐ Unknown ☐;

If yes, Name of the Facility: \_\_\_\_\_ Diagnosis at the Facility: \_\_\_\_\_

Vaccination Information obtained from: Road to health card ☐ Self reported ☐ Not obtained ☐

Measles vaccination received:

Y ☐ N ☐ Unknown ☐If yes, number of doses: 1 ☐ 2 ☐ >2 ☐

Date of last measles vaccine: \_\_\_\_/\_\_\_\_/\_\_\_\_

**RESPONSE TO CASE**Case Notified: Y ☐ N ☐ Unknown ☐ Date of Notification \_\_\_\_/\_\_\_\_/\_\_\_\_

Contacts follow-up	Number			Action Taken
	< 5 yrs	5-14 yrs	>=15 yrs	
Household				
School/Creche				
Other (Specify) _____				
Active Case Finding: Y <input type="checkbox"/> N <input type="checkbox"/> Number of suspected measles cases found: None <input type="checkbox"/> or specify number _____				

**NB: Complete an additional case investigation form for each suspected measles case identified**