

## Appendix A: CASE RECORD REVIEW FORM

### Section 1: History

Personal details					
Snum	Study number				
Dob	Age at admission				
Sex	Sex				
Doa	Date of admission				
Dod	Date of diagnosis (of measles)				
Main complaint					
rash	Rash (Y/N)	Yes <input type="checkbox"/> No <input type="checkbox"/>	dRash	Duration	
Pres	No. of days between rash & presentation		dPres	Duration	
Conj	Conjunctivis (Y/N)	Yes <input type="checkbox"/> No <input type="checkbox"/>	dCon	Duration	
Cor	Coryza (Y/N)	Yes <input type="checkbox"/> No <input type="checkbox"/>	dCor	Duration	
Fev	Fever (Y/N)	Yes <input type="checkbox"/> No <input type="checkbox"/>	dFev	Duration	
Cou	Cough (Y/N)	Yes <input type="checkbox"/> No <input type="checkbox"/>	dCou	Duration	
oSx1	Other symptom		doSx1	Duration	
oSx2	Other symptom		doSx2	Duration	
oSx3	Other symptom		doSx3	Duration	

Contact History				
CH	Any history of contact with a suspected measles case in the 7-28 days prior to admission?	1= Yes	2= No	3= Unknown

HIV status – Child						
HIVe	HIV exposed?	1= Yes		2= No		3= Unknown
HIVp	HIV PCR/ *Elisa	1= Positive		2= Negative	3= Early Neg	4= Unknown
PMC	PMTCT given?	1= No	2= NVP	3= NVP + AZT	4= N/A	5= Unknown
ARV	On HAART	<input type="checkbox"/> Yes <input type="checkbox"/> No				
ARVd	Time on HAART	Months				
CD4	CD4% prior to admission			CD4d	Date of CD4	
VL	Viral load prior to admission			VLd	Date of VL	

Vaccination status – Child					
RMV	Did child receive measles vaccine	1= Yes	2= No	3= Unknown	
RMT	If Yes, confirmation through	1= RTHC	2=Self -report	3=Not documented	
MVD	Total number of measles vaccine doses received, and age at which received	1= zero doses	2= one dose _____	3= two doses _____	4= > two doses _____
RVA	Routine Vitamin A given?	Yes-	No-	Unknown	
RVAd	Number of Vit. A doses given	1=	2=		

Feeding				
BF	Breastfeeding?	1= Yes, current	2= Yes, previously	3= Never
BFs	If BF stopped, at what age?	Months		
FF	Formula feeding?	1= Yes, current	2= Yes, previously	3= Never
MF	Any mixed feeding	1= Yes, current	2= Yes, previously	3= Unknown
fam	On Normal family diet	1=yes	2= No	3= Unknown

## Section 2: Examination.

Anthropometrics						
Wt	Weight (kg)					
Lt	Length/Height (cm)					
HC	Head circumference (cm)					
WHO	WHO severe malnut	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Well	Wellcome class	1= Normal	2= Under	3= Maras	4= Kwashi	5= Mar-Kw

Complications				
Non	None	Ltb	LTB	
Pne	Pneumonia	Cor	Corneal Ulceration	
Oti	Otitis Media	Bli	Blindness	
Diar	Diarrhoeal	Enc	Encephalitis	
Fsei	Febrile Seizures	Oth	Other specify	

## Section 3: Laboratory values on admission

<b>FBC</b>	WCC	Hb	Plts
<b>Urine</b>	Dipstix	Micro	Culture
<b>Blood culture</b>			
<b>Tuberculosis</b>	PPD		AFB's
<b>Other</b>			

Type of specimen collected for measles																															
Bld	Blood	<input type="checkbox"/> Yes <input type="checkbox"/> No																													
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Uri	Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No																													
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Nsp	Nasopharyngeal swab	<input type="checkbox"/> Yes <input type="checkbox"/> No																													
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#### Section 4: Management

Rx given during hospital stay							
hABC 1-11	Antibiotics	1= Ampi	2= Genta	3= Tazocin	4= Amik	5= Mero	6= Vanco
		7= Ceph	8= Clox	9= Bactrim	10= TB Rx	11= Other:	
hARV	HAART	<input type="checkbox"/> Yes <input type="checkbox"/> No					
hMaln 1-5	Malnut regime etc:	1= Mist KCl	2= Zinc		3= MVT		
		4= Folate	5= Iron				
hOth	Vitamin A	Number of doses 1=					
		2=					

#### Section 5: Outcome

Outc	Outcome	1= Discharged home	2= Died	3= Transferred out	4= RHT
dOut	Date of outcome				
dDx1	Other diagnoses				
dDx2	Other diagnoses				
dDx3	If died cause of death				

Appendix B: Notification form review:

Study number:

Are the following filled in?									
G/5	GW17/5 form	<input type="checkbox"/>	<input type="checkbox"/>	CX	Complications	<input type="checkbox"/>	<input type="checkbox"/>		
		Yes	No			Yes	No		
G/3	GW17/3 form	<input type="checkbox"/>	<input type="checkbox"/>	CM	Clinical management	<input type="checkbox"/>	<input type="checkbox"/>		
		Yes	No			Yes	No		
MCF	Measles case investigation form	<input type="checkbox"/>	<input type="checkbox"/>	SPC	Specimen collected	<input type="checkbox"/>	<input type="checkbox"/>		
		Yes	No			Yes	No		
NOP	Name of patient	<input type="checkbox"/>	<input type="checkbox"/>	VAC	Vaccine information	<input type="checkbox"/>	<input type="checkbox"/>		
		Yes	No			Yes	No		
ADD	Address	<input type="checkbox"/>	<input type="checkbox"/>	NOD	Number of doses received	<input type="checkbox"/>	<input type="checkbox"/>		
		Yes	No			Yes	No		
NUM	Contact number	<input type="checkbox"/>	<input type="checkbox"/>	CAR	Case response	<input type="checkbox"/>	<input type="checkbox"/>		
		Yes	No			Yes	No		
GEN	Gender	<input type="checkbox"/>	<input type="checkbox"/>						
		Yes	No						
TBc	Symptoms	1=	2=						
		Yes	No						

## Appendix C: Case Management (Public Health)

Study number:

Where the following steps completed?									
G7F	GW17/5 filled	<input type="checkbox"/>	<input type="checkbox"/>	G7F <sub>t</sub>	Timing	On admission <input type="checkbox"/> Yes <input type="checkbox"/> No			
MCF	Measles case investigation form filled	<input type="checkbox"/>	<input type="checkbox"/>	MCF <sub>t</sub>	Timing	On admission <input type="checkbox"/> Yes <input type="checkbox"/> No			
MFC	Form collected by Infection control	<input type="checkbox"/>	<input type="checkbox"/>	MFC <sub>t</sub>	Number of days from admission				
LIC	Name on list in infection control	<input type="checkbox"/>	<input type="checkbox"/>	LIC <sub>t</sub>	Number of days from admission				
RPH	Name referred to public health officer	<input type="checkbox"/>	<input type="checkbox"/>	RPH <sub>t</sub>	Number of days from admission				
RDH	Name referred to district health officer	<input type="checkbox"/>	<input type="checkbox"/>	RDH <sub>t</sub>	Number of days from admission				
RSH	Name referred to Local health authority	<input type="checkbox"/>	<input type="checkbox"/>	RSH <sub>t</sub>	Number of days from admission				
RDP	Response from district sent to PH office	<input type="checkbox"/>	<input type="checkbox"/>	RDP <sub>t</sub>	Number of days from admission				
HVD	Home visit done	1= Yes	2= No	3= Unknown					

Contact tracing

Contacts				
HOU	Number of Household contacts			
SCH	Number of School/crèche contacts			
Oh	Other			
ACT	Active measles cases	1= Yes, current	2= Yes, previously	3= Unknown
	Action taken by district team	Vaccinated-	Referred for treatment	