MEASLES CASE INVESTIGATION FORM

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 □
Laryngotraechobronchitis (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 ___/___/___

<table>
<thead>
<tr>
<th>Contacts follow-up</th>
<th>Number</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household</td>
<td>&lt; 5 yrs</td>
<td>5-14 yrs</td>
</tr>
<tr>
<td>School/Creche</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Active Case Finding: Y □ N □ Number of suspected measles cases found: None □ or specify number ____________________________

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