

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 DETAILSFull 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 PRESENTATIONPresenting 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 CASECase 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