Measles

Agency:
Investigator:
Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: ____________________
First and middle name: ____________________
Maiden name: __________ Suffix: __________
Address line: ____________________
Zip: ________ City: ____________
State: ________ County: ____________
Phone: ( )- - ________ Type: ________
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name: ____________________

Date of Birth: / / Estimated? ☐ Age: ______
Gender: ☐ Female ☐ Male ☐ Other _____
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name: ____________________
Parent/Guardian phone: ( )- - ________ Type: ________

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ____________________
Exposure setting: ____________________
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: ____________
Location acquired:
☐ In USA, in reporting state
☐ In USA, outside reporting state
☐ Outside USA
☐ Unknown
State: ________ Country: ________

Healthcare provider information

Last name: ____________________
First name: ____________________
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name: ____________________
Address line 1: ____________________
Address line 2: ____________________
Zip code: ____________ City: ____________
State: ____________ County: ____________
Phone : ( )- - ________ Type: ________

LABORATORY FINDINGS

Laboratory: ____________ Accession #: ____________ Collection date: / /
Date received: / / Specimen source: ____________ Test type: ____________
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Measles virus

Laboratory: ____________ Accession #: ____________ Collection date: / /
Date received: / / Specimen source: ____________ Test type: ____________
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Measles virus

Laboratory: ____________ Accession #: ____________ Collection date: / /
Date received: / / Specimen source: ____________ Test type: ____________
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Measles virus

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: ____________________ Job title: ____________________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________________
Date worked from: ___/___/___ Address: ____________________
Date worked to: ___/___/___ Zip code: ____________________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: __________ State: ______ County: __________
Date removed: ___/___/___ Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: ____________________ Job title: ____________________
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________________
Date worked from: ___/___/___ Address: ____________________
Date worked to: ___/___/___ Zip code: ____________________
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: __________ State: ______ County: __________
Date removed: ___/___/___ Phone: ( )- - Type:
Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ____________________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): __________
Admission date: ___/___/___ Discharge date: ___/___/___ Days hospitalized: __________
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms

Fever ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___ Duration: ______ hrs/days Date returned to normal activities: ___/___/___
Cough ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___
Runny nose ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___
Red eyes w/t drainage ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___
Diarrhea ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___
Thrombocytopenia ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___
Arthritis ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___
Other complications: ______ Describe: ____________________

____

Other symptoms

- ☐ Abdominal cramps
- ☐ Backache
- ☐ Chills
- ☐ Encephalitis
- ☐ Fatigue
- ☐ Fever
- ☐ Sore throat
- ☐ Vomiting
- ☐ Headache
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Nausea
- ☐ Otitis media
- ☐ Photophobia

Rash: ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___ Duration: ______ hours/days
Fever continued w/t rash: ☐ Yes ☐ No ☐ Unk Rash spreading: ☐ Yes ☐ No ☐ Unk
Rash equally distributed: ☐ Yes ☐ No ☐ Unk Rash appeared at once: ☐ Yes ☐ No ☐ Unk
Lesions present: ☐ Yes ☐ No ☐ Unk Rash initial location: ☐ Arms ☐ Face ☐ Legs ☐ Trunk ☐ Inside mouth

______ cm

Heaviest lesion area: ☐ Arms ☐ Face ☐ Legs ☐ Trunk ☐ Scalp

# of days for first lesion to crust: ______ days

Areas present: ☐ Inside mouth ☐ Palms ☐ Soles

Lesions in same stage of development: ☐ Yes ☐ No ☐ Unk

Severity: ☐ < 50 lesions ☐ 50 – 249 lesions ☐ 250 – 500 lesions ☐ > 500 lesions

Rash characteristics:
☐ Burning
☐ Confluent lesions
☐ Could be felt (papule)
☐ Could not be felt (macule)
☐ Discrete lesions
☐ Distinct sharp borders
☐ Dusky brown
☐ Marked itching
☐ Numbness
☐ Painful
☐ Peeling skin
☐ Pustule
☐ Reddish
☐ Scaling/crusting

Koplik's spots: ☐ Yes ☐ No ☐ Unk

Healthcare provider visited: ☐ Yes ☐ No ☐ Unk

Date(s) visited: ___/___/___, ___/___/___, ___/___/___

Swollen lymph nodes: ☐ Yes ☐ No ☐ Unk

Location: ______________________

TREATMENT

Antivirals prescribed: ☐ Yes ☐ No ☐ Unknown

Antiviral: ______	Antiviral: ______	Antiviral: ______
Date started: ___/___/___	Date started: ___/___/___	Date started: ___/___/___
Dose: ______	Dose: ______	Dose: ______
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of days: ______	# of days: ______	# of days: ______
# of times a day: ______	# of times a day: ______	# of times a day: ______
Route: ______	Route: ______	Route: ______

Therapeutic medications prescribed? ☐ Yes ☐ No ☐ Unk

List medications: ______________________

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.

EXPOSURE PERIOD ☐ The incubation period for **measles** is up to 21 days. ☐ **Onset** ☐ **COMMUNICABLE PERIOD** **Measles** is communicable 1 day *before* the onset of symptoms to 4 days after the rash appearance. ☐

RISK FACTORS/TRAVEL

Vaccinated with MMR: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: ___/___/___	Date vaccinated: ___/___/___	Date vaccinated: ___/___/___
Lot #: ______	Lot #: ______	Lot #: ______
Vaccine type: ______	Vaccine type: ______	Vaccine type: ______
Manufacturer: ______	Manufacturer: ______	Manufacturer: ______

Number of vaccinations: ____

In the 21 days prior to the onset of symptoms did the case:

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: ______ Departure date: ___/___/___ Return date: ___/___/___

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ______ City: ______ Departure date: ___/___/___ Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: ______ Departure date: ___/___/___ Return date: ___/___/___

Born outside the U.S.? ☐ Yes ☐ No ☐ Unknown Country outside the U.S.: ______

Immunocompromised? ☐ Yes ☐ No ☐ Unknown

In the 1 day prior to the onset of rash through 4 days after the onset of rash did the case:

Use public transportation: ☐ Yes ☐ No ☐ Unk

Date(s) used:	Time(s) used:	Type:	Route:
/ /			
/ /			
/ /			

Visit a doctor's office, clinic or hospitals: ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Facility name:				Facility name:			
Address:				Address:			
Zip code:		City:		Zip code:		City:	
State:		County:		State:		County:	
Phone:	( )- -	Type:		Phone:	( )- -	Type:	
Date visited:	/ /	Time visited:		Date visited:	/ /	Time visited:	
Provider name:		Title:		Provider name:		Title:	

Visit a public places: ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Phone	Date(s) visited	Time visited
		( )- -	/ /	
		( )- -	/ /	
		( )- -	/ /	

Attend religious gatherings: ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Attend family gatherings: ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Attend other gatherings: ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Setting Acquired:

Child care ☐ Yes ☐ No ☐ Unk
Church ☐ Yes ☐ No ☐ Unk
College ☐ Yes ☐ No ☐ Unk
Correctional Facility ☐ Yes ☐ No ☐ Unk
Doctors office ☐ Yes ☐ No ☐ Unk

Hospitalized ☐ Yes ☐ No ☐ Unk
International traveler ☐ Yes ☐ No ☐ Unk
Military ☐ Yes ☐ No ☐ Unk
Hospital ER/ Outpatient ☐ Yes ☐ No ☐ Unk

Home ☐ Yes ☐ No ☐ Unk
School ☐ Yes ☐ No ☐ Unk
Urgent care ☐ Yes ☐ No ☐ Unk
Work ☐ Yes ☐ No ☐ Unk
Other

Disease traced within 2 generations of known international import? ☐ Yes ☐ No ☐ Unk

CONTACTS

Number of people living in case's household: _____

Close contacts of the case (For more than one contact, print/copy additional contact pages.)

Last name: ______________________ Address: ______________________

First name: ______________________ City/State/Zip: ______________ County: __________

DOB: ___/___/______ Age: ______ Phone: ______________ Type: __________

Gender: ☐ Female ☐ Male ☐ Other Symptoms present: ☐ Yes ☐ No ☐ Unk Onset date: ___/___/___

If this contact has an onset date before this case then create a new case and event.

Symptoms:

Fever ☐	Onset date: ___/___/___	Vomiting ☐	Onset date: ___/___/___
Runny nose ☐	Onset date: ___/___/___	Cough ☐	Onset date: ___/___/___
Rash ☐	Onset date: ___/___/___	Red eyes w/t discharge ☐	Onset date: ___/___/___
Chills ☐	Onset date: ___/___/___	Backache ☐	Onset date: ___/___/___
Fatigue ☐	Onset date: ___/___/___	Encephalitis ☐	Onset date: ___/___/___
Joint pain ☐	Onset date: ___/___/___	Headache ☐	Onset date: ___/___/___
Nausea ☐	Onset date: ___/___/___	Muscle pain ☐	Onset date: ___/___/___
Photophobia ☐	Onset date: ___/___/___	Otitis media ☐	Onset date: ___/___/___
Sore throat ☐	Onset date: ___/___/___	Pneumonia ☐	Onset date: ___/___/___
		Swollen lymph nodes ☐	Onset date: ___/___/___

Vaccinated for measles (MMR): ☐ Yes ☐ No ☐ Unk Number of vaccinations:

Date vaccinated: ___/___/______	Date vaccinated: ___/___/______	Date vaccinated: ___/___/______
Lot #: __________	Lot #: __________	Lot #: __________
Vaccine type: __________	Vaccine type: __________	Vaccine type: __________
Manufacturer: __________	Manufacturer: __________	Manufacturer: __________

Exposed to measles: ☐ Yes ☐ No ☐ Unk

Received IG within 6 days of exposure: ☐ Yes ☐ No ☐ Unk

Received MMR within 3 days of exposure: ☐ Yes ☐ No ☐ Unk

Date received: ___/___/___ Dose: Unit: Route:

Tested for immunity: ☐ Yes ☐ No ☐ Unk Result: ☐ IgM+ ☐ IgM- ☐ IgG+ ☐ IgG-

Is this contact a case? ☐ Yes ☐ No ☐ Unk

NOTES:

PROPHYLAXIS

Name	DOB	Exposed to case	Vaccinated for measles	Number of doses	Dates of vaccination	Received MMR due to this exposure	Received IG due to this exposure	Notes
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
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	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
	/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk		/ /	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	