Georgia Department of Public Health Measles Case Report Form

Sendss ID: ______ Form Complete: ☐Yes ☐No

PATIENT DEMOGRAPHICS

Patient First: ____________ M.I.: ________ Last: ____________

Date of Birth: (mm/dd/yy) __/__/__

Age *(enter age and check one)*: ___ ☐ Days ☐Weeks ☐Months ☐ Years

Sex: ☐M ☐F ☐Other ☐ Unknown

Address: ____________ City: ________ County: ________ GA ZIP: ________

Telephone number: Home ( ) -- Work ( ) --

Country of birth: ____________

Ethnicity (check one):
☐Hispanic/Latino
☐Non-Hispanic/Latino
☐Unknown

Race (check all that apply):
☐ Black/African American
☐ Native American/Alaskan Native
☐ White
☐ Asian/Pacific Islander
☐ Multiracial
☐ Other (please specify): ____________
☐Unknown

TRACKING DATA

Medical Record no. or client no.: ____________

State Case ID **(*For state use only*):** ____________

Date reported to health department (mm/dd/yy): __/__/__

Date investigation started: __/__/__

Person/clinician reporting: ____________

Reporter telephone: ( ) -

Case investigator completing form: ____________

Organization: ____________

Investigator Phone: ( ) -

Event Date __/__/__

Event Type: ☐Rash Onset Date ☐Diagnosis Date ☐Lab Test Date ☐Unknown ☐Report Date (County) ☐Report Date (State)

SIGNS AND SYMPTOMS

Rash: ☐Yes ☐No ☐Unknown

Rash onset date: __/__/__

Rash duration: ________ days

Generalized rash?: ☐Yes ☐No ☐Unknown

Origin on body: ________

Direction of spread: ________

Was temperature taken?: ☐Yes ☐No ☐Unknown

Fever?: ☐Yes ☐No ☐Unknown

Fever onset date: __/__/__

Highest Recorded Temperature: ______ °F (Unk=999.9)

If temperature not taken, skin was: ☐Hot ☐Warm ☐Normal ☐Unknown

Symptom				Onset date
Cough?	☐Yes	☐No	☐Unknown	__/__/__
Coryza?	☐Yes	☐No	☐Unknown	__/__/__
Conjunctivities	☐Yes	☐No	☐Unknown	__/__/__
Koplik's spots	☐Yes	☐No	☐Unknown	__/__/__

Other symptoms?:
☐ Yes
☐ No
☐ Unknown

Describe additional symptoms: ____________

Does the case meet clinical criteria for further investigation?: ☐Yes ☐No ☐Unknown

CASE MEETS CDC/CSTE CLINICAL CRITERIA? *(FOR STATE USE ONLY)*: ☐Yes ☐ No ☐Unknown

COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized? ☐Yes ☐No ☐Unknown

Admission Date: __/__/__

Discharge Date: __/__/__

Number of days hospitalized: ____________

Died?:
☐ Yes
☐ No
☐ Unknown

Date of Death: __/__/__

Facility Name: ____________

Pneumonia?: ☐Yes ☐No ☐Unknown

Encephalitis?: ☐Yes ☐No ☐Unknown

Other complications?: ☐Yes ☐No ☐Unknown

If died, complete and attach measles death worksheet

LABORATORY TESTS

Result Codes: P: Positive X: Not done N: Negative I: Indeterminate E: Pending U: Unknown
Specimen Type Codes: U: Urine S: Blood/Serum N: Nasopharyngeal swab T:Throat swab O: Other U: Unknown

Was laboratory testing done for measles? ☐Yes ☐No ☐Unknown

Case lab confirmed (For State use Only) ☐Yes ☐No ☐Unknown

Virus isolated?: ☐Yes ☐No

	Result	Date specimen taken	Lab Name
Culture	______	__/__/__	________
PCR	______	__/__/__	________
IgM	______	__/__/__	________
IgG (acute)	______	__/__/__	________
IgG (convalescent)	______	__/__/__	________

Specimen sent to CDC genotyping? ☐ Yes ☐No ☐Unknown

Date sent to CDC: __/__/__

Virus genotype: ____________

Comments:

Please fax completed form to your District Health Department

VACCINATION HISTORY

Ever received one or more doses of measles-containing vaccine? ☐Yes ☐No ☐Unknown

Number of doses received prior to illness onset: _____ Doses

Dose	Vaccination Date	Vaccine Type	Vaccine manufacturer	Lot Number
Dose 1	__/__/__			
Dose 2	__/__/__			

Prior MD diagnosis of measles? ☐Yes ☐No ☐Unknown

Reason for not being age-appropiately vaccinated:

☐ Religious Exemption **(1)**
☐ Parental/Patient refusal **(2)**
☐ Philosophical exemption **(3)**
☐ Lab confirmation of previous disease **(4)**
☐ Medical contraindication **(5)**
☐ MD diagnosis of previous disease **(6)**
☐ Unknown **(7)**
☐ Forgot **(8)**
☐ Inconvenience **(9)**
☐ Too expensive **(10)**
☐ Other **(11)** (specify): __________
☐ Too young **(12)**
☐ Unaware **(13)**

EPIDEMIOLOGIC INFORMATION

Date first reported to public health: __ /__/__

Epi-linked? ☐Yes ☐No ☐ Unknown

Name of epi-linked case:

____

SendSS ID of Epi-linked case:

____

Outbreak related?: ☐Yes ☐No ☐ Unknown

Outbreak name or location:

____

Employed at or attends school? ☐Yes ☐No ☐Unknown

Employed at or attends child care? ☐ Yes ☐No ☐Unknown

Is the patient incarcerated?: ☐Yes ☐No ☐ Unknown

Is the patient institutionalized?: ☐Yes ☐No ☐ Unknown

Is the patient pregnant?: ☐Yes ☐ No ☐ Unknown

Is patient immunocompromised?: ☐ Yes ☐No ☐ Unknown

Is the patient a healthcare worker?:

☐ Yes, w/ direct patient contact
☐ Yes, without direct patient contact
☐ No
☐ Unknown

EXPOSURE HISTORY

Recent travel or arrival from other country or state within 18 days of rash onset? ☐Yes ☐ No ☐Unknown

Type of travel: ☐International ☐Domestic

Visted tourist attraction? ☐ Yes ☐No ☐ Unknown

Date returned to Georgia: __ /__/__

Country or state visited 1:	Dates of travel: __ /__/__ to __ /__/__
Country or state visited 2:	Dates of travel: __ /__/__ to __ /__/__
Country or state visited 3:	Dates of travel: __ /__/__ to __ /__/__
Tourist attraction visited:	Dates of travel: __ /__/__ to __ /__/__

Close contact with person(s) with rash 8-17 days before rash onset? Yes No Unknown

	Name	Rash onset date	Relationship	Age (years)	Same Household
1		___/ ___ /___			
2		___ /___ /___			
3		___/___ /___			
4		___ /___ /___			

Transmission Setting (Where did this case acquire measles?)
☐Daycare (1) ☐School (2) ☐Work (3) ☐Hospital Ward (4) ☐Hosptial ER (5) ☐Outpatient clinic (6) ☐Home (7) ☐Doctor's Office (8)
☐ Unknown (9) ☐College (10) ☐Military (11) ☐ Correctional facility (12) ☐ Place of worship (13) ☐ International Travel (14)

Setting of further documented spread from case (outside of household)(use number codes from transmission setting question) __________
(no documented spread = 16)

Import status: ☐Indigenous ☐Out-of-state import ☐International Import

Indigenous case: ☐import linked (linked to imported case) ☐Endemic
☐ Imported virus (viral genertic evidence indcateds an imported genotype)
☐ Unknown source

Imported case: describe source

Number of susceptible contacts:

____

Comments: