Georgia Department of Public Health
Measles Case Report Form

SendSS ID: _____

Form Complete □ Yes □ No

PATIENT DEMOGRAPHICS

Patient name: Last, First M.I.	Date of birth (mm/dd/yy): ____/____/____	Age *(enter age and check one):* ___ □ Days □ Weeks □ Months □ Years	Gender: □ Male □ Female

Address: Number, Street	City:	State:	ZIP code:	County:

Telephone number: Home ( ) – Work ( ) –	Country of birth:

Ethnicity (check one):	Race (check all that apply):		
□ Hispanic/Latino	□ Black/African-American	□ Asian /Pacific Islander	□ Unknown
□ Non-Hispanic/Latino	□ Native American/Alaskan Native	□ Multiracial	
□ Unknown	□ White	□ Other (please specify) _____	

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 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	If temperature not taken, skin was □ Hot □ Warm □Normal □Unknown

Cough? □Yes □No □Unknown	Onset date ___/____/____	Other symptoms? □ Yes □ No □ Unknown	Describe additional symptoms
Coryza? □Yes □No □Unknown	Onset date ___/____/____		
Conjunctivitis □Yes □No □Unknown	Onset date ___/____/____		
Koplik's spots □Yes □No □Unknown	Onset date ___/____/____		

Does case meet clinical criteria for further investigation? □ Yes □ No □ Unknown	**CASE MEETS CDC/CSTE CLINICAL CRITERA? (*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:			**If died, complete and attach measles death worksheet**

Pneumonia? □ Yes □ No □ Unknown	Encephalitis? □ Yes □ No □ Unknown	Other complications? □ Yes □ No □Unknown

Describe additional complications:

LABORATORY TESTS

Was laboratory testing for measles done? □ Yes □ No □ Unknown	Case lab confirmed ***(For state use only)*** □ Yes □ No □ Unknown	Virus isolated? □ Yes □ No □Unknown

	Result	Date specimen taken	Lab name	Specimen Type
Culture	_____	____/____/____	_____	_____
PCR	_____	____/____/____	_____	_____
IgG (acute)	_____	____/____/____	_____	_____
IgG (convalescent)	_____	____/____/____	_____	_____
IgM	_____	____/____/____	_____	_____

Specimen sent to CDC for genotyping? □Yes □No □Unknown

Date sent to CDC ___/___/_____

Virus genotype _____

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

Comments:

VACCINATION HISTORY

Vaccinated? (Received any doses of measles-containing vaccines)
□ Yes □ No □ Unknown

No. doses of measles-containing vaccine received prior to illness onset? _____

Dose	Vaccination date	Vaccine type	Vaccine manufacturer	Lot number
Dose 1	____/____/____			
Dose 2	____/____/____			

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

Reason patient not **age-appropriately** vaccinated

□ Religious exemption
□ Parental/Patient refusal
□ Philosophical exemption
□ Lab confirmation of previous disease
□ Medical contraindication
□ MD diagnosis of previous disease
□ Unknown
□ Forgot
□ Inconvenience
□ Too expensive
□ Other
□ Too young
□ Unaware

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 patient incarcerated? □ Yes □ No □ Unknown

Is patient instutionalized? □ Yes □ No □ Unknown

Is patient pregnant? □ Yes □ No □ Unknown

Is patient immunocompromised? □ Yes □ No □ Unknown

Is patient a healthcare worker?
□ Yes, w/ direct patient contact
□ Yes, w/o 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

Visited tourist attraction? □Yes □No □Unknown

Countries or states visited:

Dates in countries or states visited
___/___/____ to ___/____/____

Tourist attraction visited: ___/___/____ to ___/____/____

Date returned to Georgia
____/____/_____

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 pertussis?)

□ Daycare (1)
□ School (2)
□ Doctor's Office (3)
□ Hospital Ward (4)
□ Hospital ER (5)
□ Outpatient clinic (6)
□ Home (7)
□ Work (8)
□ Unknown (9)
□ College (10)
□ Military (11)
□ Correctional facility (12)
□ Place of worship (13)
□ International travel (14)
□ Other (15)

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

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

If case is indigenous, is case □Import-linked (linked to imported case) □ Endemic

□ Imported virus (viral genetic evidence indicates an imported genotype) □ Unknown Source

If case is imported, describe source

Number of susceptible contacts _____

Comments: