



**Immediately notify
DOH Communicable
Disease Epidemiology
Phone: 877-539-4344**

LHJ Use ID _____

Reported to DOH Date ___/___/___

LHJ Classification Confirmed
 Probable

By: Lab Clinical
 Epi Link: _____

Outbreak-related

LHJ Cluster# _____

LHJ Cluster Name: _____

DOH Outbreak # _____

Measles

County _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___

Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other

OK to talk to case? Yes No DK Date of interview ___/___/___

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact Parent/guardian Spouse Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____

Gender F M Other Unk

Ethnicity Hispanic or Latino
 Not Hispanic or Latino

Race (check all that apply)

Amer Ind/AK Native Asian

Native HI/other PI Black/Afr Amer

White Other Unk

CLINICAL INFORMATION

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: ___ days

Signs and Symptoms

Y N DK NA

Fever Highest measured temp: _____ °F
Type: Oral Rectal Other: _____ Unk
Onset date: ___/___/___ Duration ___ days

Runny nose (coryza) Onset date: ___/___/___

Cough Onset date: ___/___/___

Rash Onset date ___/___/___ Duration ___ days

Flat spots ___ Raised spots ___ Both ___

Blisters/Pustules ___ Blotchy ___ Color: _____

Where did it first appear? _____

Rash progression: _____

Where was it most intense? _____

Does the rash itch? Yes ___ No ___

Sore throat Onset date: ___/___/___

Seizures new with disease Onset: ___/___/___

Diarrhea Onset date: ___/___/___

Y N DK NA

Hospitalized at least overnight for this illness

Hospital name _____

Admit date ___/___/___ Discharge date ___/___/___

Y N DK NA

Died from illness Death date ___/___/___

Autopsy Place of death _____

Vaccination

Y N DK NA

Ever received measles containing vaccine

Dose 1 Type: _____ Date received: ___/___/___

Dose 2 Type: _____ Date received: ___/___/___

Dose 3 Type: _____ Date received: ___/___/___

Vaccine up to date for measles

Number of doses on or after the 1st birthday: _____

Number of doses before the 1st birthday: _____

Vaccine series not up to date reason:

Religious exemption Medical contraindication

Philosophical exemption

Previous infection confirmed by laboratory

Previous infection confirmed by physician

Parental refusal Other: _____ Unk

Clinical Findings

Y N DK NA

Conjunctivitis

Koplik spots

Rash observed by health care provider

Rash distribution: _____

Generalized Localized On palms and soles

Patechial Macular Papular

Pustular Vesicular Bullous

Other: _____

Photophobia

Otitis media

Pneumonia or pneumonitis

Encephalitis or encephalomyelitis

Lymphadenopathy Onset date: ___/___/___

Cervical Suboccipital

Postauricular Other: _____

Thrombocytopenia

Complications

Specify: _____

Laboratory

Collection date ___/___/___

Source _____

P N I O NT

Measles virus culture (from blood or nasopharyngeal mucosal swab before day 4 of rash, or urine specimen before day 8 of rash)

Measles IgG with significant rise (acute and convalescent serum pair)

Measles IgM (serum ≥ 4 days after rash onset)

Measles virus nucleic acid detection (PCR)

Tests to rule out other agents

Agent/results: _____ Date: ___/___/___

Agent/results: _____ Date: ___/___/___

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

INFECTION TIMELINE

Enter prodromal fever and rash onset dates. Count forward and backward to figure probable exposure and contagious periods.

Exposure period

Days from fever onset:

Calendar dates:

PRODROME
o
n
s
e
t

RASH
o
n
s
e
t

Contagious period

EXPOSURE (Refer to dates above)

Y N DK NA

- Travel out of the state, out of the country, or outside of usual routine
Out of: County State Country
Destinations/Dates: _____
- Contact with recent foreign arrival
Specify country: _____
- Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____
- Traceable within 2 generations to internat'l import
- Visited or worked in health care setting 1 - 3 weeks preceding onset
Facility name: _____
Number of visits: _____ Date(s): ___/___/___
- Does the case know anyone else with similar symptoms or illness
- Epidemiologic link to a confirmed or probable case**

Y N DK NA

- Attended gathering 1 - 3 weeks preceding onset
- Congregate living
 Barracks Corrections Long term care
 Dormitory Boarding school Camp
 Shelter Other: _____
- Exposure setting identified:
 Child care School Doctor's office
 Hospital ward Hospital ER
 Hospital outpatient clinic Home
 College Work Military
 Correction facility Church
 International travel
 Other, specify: _____ Unknown
- Antibiotic use in the week before rash onset:
Specify: _____

Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified**
- Patient could not be interviewed**

PUBLIC HEALTH ISSUES

Y N DK NA

- Attends child care or preschool
- Employed in child care or preschool
- Do any household members work at or attend child care or preschool
- Work/volunteer in health care setting while contagious: Facility name: _____
- Visited health care setting while contagious
Facility name: _____
Number of visits: _____ Date(s): ___/___/___
- Documented transmission from this case
 Child care School Doctor's office
 Hospital ward Hospital ER
 Hospital outpatient clinic Home
 College Work Military
 Correction facility Church
 International travel Other: _____ Unk

PUBLIC HEALTH ACTIONS

- Isolate and exclude case from work, school and all public settings
- Evaluate immune status of close contacts,**
Date initiated: ___/___/___
- Prophylaxis of appropriate contacts recommended
Number of contacts recommended prophylaxis: _____
Number of contacts receiving prophylaxis: _____
Number of contacts completing prophylaxis: _____
- Exclude exposed susceptibles from work/school for incubation period
- Recommend respiratory isolation if in a health care setting

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ___/___/___

Local health jurisdiction _____

Record complete date ___/___/___