MEASLES CASE INVESTIGATION FORM (JULY 2017)

EPID NUMBER: SOA - _____-_____-_____-_____

(Will be assigned at Provincial Office) Country Prov Code District Code Year Onset Case number

PATIENT DETAILS

Full name: _____ Gender: M ☐ F ☐ Unknown ☐

Date of birth: ____/____/____ If DOB unknown Age: ___ Unit: Days ☐ Wks ☐ Months ☐ Yrs ☐

Street address:_____

Health District _____Town/ City: _____ Province: _____ Contact Number(s): _____

CURRENT PRESENTATION

Presenting symptoms/signs (Tick all applicable Boxes): Rash ☐ Fever ☐ Conjunctivitis ☐ Cough ☐

Coryza/Rhinitis/runny nose ☐ Other (Specify)_____

Presenting complications (Tick where applicable): None ☐ Pneumonia ☐ Otitis Media ☐ Diarrhoea ☐ Febrile seizures ☐ Laryngotracheobronchitis (Croup) ☐ Corneal Ulceration ☐ Blindness ☐Encephalitis ☐ Other: _____

Date of onset of rash: _____/_____/_____

Date of Presentation at the health facility: _____/_____/_____

Name of health facility:_____

Is the patient admitted? Y ☐ N ☐ Date of admission: _____

Diagnosis at health facility: _____

Clinical Management: Vitamin A given: Y ☐ N ☐ Number of doses ☐

Specimens Collected (Tick where applicable): Blood/Serum ☐ Nasopharyngeal ☐ Dried Blood Spot ☐ Date of specimen collection: _____/_____/_____

Case Notified: Y ☐ N ☐ Date of Notification_____/_____/_____

MEDICAL AND CONTACT HISTORY

History of contact with a suspected measles case in the past 7 to 28 days: Y ☐ N ☐ Unknown ☐ Date of Depature: _____/___/___

History of contact with a confirmed measles case in the past 7 to 28 days: Y ☐ N ☐ Unknown ☐ Date of return: _____/_____/_____

History of travel :Y ☐ N ☐Unknown ☐ if yes, travel destination (s): _____ Travel date (s): _____

History of visit or admission to a healthcare facility in the past 7 to 28 days: Y ☐ N ☐ Unknown ☐

If yes, Name of health Facility:_____Date of visit/admision _____Diagnosis at health Facility:_____

Measles vaccination received: Y ☐ N ☐ Unknown ☐ .....If yes, number of doses: 1 ☐ 2 ☐ >2 ☐

.....Date of last measles vaccination: _____/_____/_____

Vaccination Information obtained from: Road to health card ☐ Self reported ☐ Not obtained ☐

RESPONSE TO CASE :

Contacts follow-up	Number			Action Taken
	< 5 yrs	5-14 yrs	>=15 yrs	
Household				
School/Crèche				
Health Facility				
Other (Specify)_____				

Active Case Finding: Y ☐ N ☐ Number of suspected measles cases found: None ☐ or specify number_____

30 DAY FOLLOW-UP OF ALL IgM POSITIVE CASES

Complications (Tick where applicable): None ☐ Pneumonia ☐ Otitis Media ☐ Diarrhoea ☐ Febrile seizures ☐ Laryngotracheobronchitis (Croup) ☐ Corneal Ulceration ☐ Blindness ☐Encephalitis ☐ Other:

Final outcome (Tick where applicable): Patient admitted to Hospital: Y ☐ N ☐ Date admitted: _____

Patient Died: Y ☐ N ☐

Date of 30 day follow-up : _____/_____/_____ Follow-up done by: _____

NB: *Complete a separate case investigation form for each suspected measles case identified*. MEASLES CASES TO BE NOTIFIED TO THE PROVINCIAL/DISTRICT CONTACT PERSON:Name& Phone:_____EMAIL_____IMMEDIATELY SEND A COPY OF THIS COMPLETED FORM TO DISTRICT EPI coordinators Name & Phone:_____EMAIL_____IF YOU HAVE ANY QUESTIONS PLEASE CONTACT: Expanded Programme on Immunisation National Office: 012 395 9458/ 012 395 9051/012 395 9453