

MEASLES-RUBELLA CASE INVESTIGATION FORM (SEPTEMBER 2022)

EPID NUMBER: SOA - _____ - _____ - _____ - _____
(Will be assigned at Provincial Office) Country Prov Code District Code Year Onset Case number

This is a suspected case of: measles rubella uncertain

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: Y N Fever: Y N Conjunctivitis: Y N Cough: Y N
 Occipital/auricular lymphadenopathy: Y N Arthralgia: Y N Coryza/Rhinitis/Runny nose: Y N Other (Specify): _____
 Presenting complications (Tick where applicable): None Pneumonia Otitis Media Diarrhoea Febrile seizures Laryngotracheobronchitis (Croup) Corneal Ulceration Blindness Encephalitis Arthritis Other: _____ If female, is she pregnant: Yes No Unknown
 Weeks: _____
 Date of onset of rash (dd/mm/yyyy): ____/____/____ Name of health facility: _____
 Date of presentation at the health facility: ____/____/____ Is the patient admitted? Y N Date of admission (dd/mm/yyyy): ____/____/____
 Diagnosis at health facility: _____
 Clinical Management: Vitamin A given: Y N Number of doses: _____
 Specimens Collected (Tick where applicable): Blood/Serum: Y N Nasopharyngeal swab: Y N
 Date of specimen collection: ____/____/____
 Case Notified: Y N Date of Notification ____/____/____

MEDICAL AND CONTACT HISTORY

History of contact with a fever-rash case in the past 7 to 28 days: Y N Unknown
 History of contact with a confirmed rubella case in the past 7-28 days: Y N Unknown
 History of contact with a confirmed measles case in the past 7-28 days: Y N Unknown
 History of travel: Y N Unknown if yes, travel destination (s): _____ Travel date (s): _____
 Date of departure: ____/____/____ Date of return: ____/____/____
 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/admission: _____ Diagnosis at health Facility: _____
 Measles-containing vaccination received: Y N Unknown Name of measles-containing vaccine (according to road to health card): _____
 If yes, number of doses: 1 2 >2 Date of last measles vaccination: ____/____/____
 Rubella-containing vaccine received: Y N Unknown Name of rubella vaccine (according to road to health card): _____
 If yes, number of doses: 1 2 >2 Date of last rubella 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 <input type="checkbox"/> N <input type="checkbox"/>		Number of suspected measles cases found: None <input type="checkbox"/> or specify number _____		

30 DAY FOLLOW-UP OF ALL MEASLES 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: Pregnant women with a positive rubella IgM test should be referred to specialist obstetricians for evaluation. Complete a separate case investigation form for each suspected measles case identified. If you have any questions please contact.....