

## MEASLES (RUBEOLA) CASE REPORT

### PATIENT DEMOGRAPHICS

Patient name—last	first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number, street)			City	State	ZIP code
					County

**ETHNICITY** (check one)     Hispanic or Latino     Not Hispanic or Latino     Unknown

**RACE** (check all that apply)

<input type="checkbox"/> Unknown	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> African-American or Black	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Thai
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Hmong	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> White	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Other Asian: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Japanese	<input type="checkbox"/> Samoan
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Pacific Islander: _____
	<input type="checkbox"/> Korean	
	<input type="checkbox"/> Filipino	
	<input type="checkbox"/> Laotian	

Occupation (check all that apply)

Food service     Health care     Day care     School     Correctional facility     Other: \_\_\_\_\_

Country of birth \_\_\_\_\_ Country of residence \_\_\_\_\_

### COMMON LHD TRACKING DATA

CMRID number	IZB Case ID number	Web CMR ID number
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case
		Reporter telephone ( )
Case investigator completing form	Investigator telephone ( )	Investigator's LHD or jurisdiction

### SIGNS AND SYMPTOMS

Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rash onset date ____/____/____	Rash duration _____ days	Generalized rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Origin on body	Direction of spread
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Fever onset date ____/____/____	Was temperature taken <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Was temperature ≥ 101°F (38.3°C) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If temperature not taken, skin was <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Normal <input type="checkbox"/> Unknown	
Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Runny nose (coryza) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Koplik's spots <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other symptoms				Date of diagnosis ____/____/____

Does 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days hospitalized	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of death (mm/dd/yy) ____/____/____	Describe other complications		

### LABORATORY TESTS

Any lab tests done for measles <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>CASE LAB CONFIRMED (FOR LHD USE)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>CASE LAB CONFIRMED (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>LAB RESULT CODES</b> P = Positive—Evidence of recent or current infection N = Negative—Antibody not detected I = Indeterminate E = Pending X = Not done U = Unknown Z = Infection at undetermined time or immunization
Serology performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen Date	Titer Result	Test Reference Index
IgM	____/____/____		
IgG (acute)	____/____/____		
IgG (convalescent)	____/____/____		
Specimen taken for virus isolation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen source <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Specimen date ____/____/____	Virus isolated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Specimen sent to CDC for genotyping <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date sent ____/____/____	Virus genotype	
Other lab tests completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specify lab tests		Other lab test results

**VACCINATION/MEDICAL HISTORY**

Received one or more doses of measles containing vaccine (MCV) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Number of doses
Vaccination dates—Dose 1 ____/____/____	Dose 2 ____/____/____	Dose 3 ____/____/____
Reason not vaccinated (check only one)		
1 <input type="checkbox"/> Personal Beliefs Exemption (PBE)	4 <input type="checkbox"/> Lab confirmation of previous disease	7 <input type="checkbox"/> Delay in starting series or between doses
2 <input type="checkbox"/> Permanent Medical Exemption (PME)	5 <input type="checkbox"/> MD Diagnosis of previous disease	8 <input type="checkbox"/> Other
3 <input type="checkbox"/> Temporary Medical Exemption	6 <input type="checkbox"/> Under age for vaccination	9 <input type="checkbox"/> Unknown
Prior MD diagnosed measles (see reason 5) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**EXPOSURE/TRAVEL HISTORY**

Acquisition setting (check all that apply):

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional Facility	15 <input type="checkbox"/> Other

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

Countries or states visited	Dates in countries or states visited	Date of arrival in California ____/____/____
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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		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing work sheet.

Epi-linked to a confirmed case <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case name or Case ID	Outbreak related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outbreak name or location
Import status (FOR LHD USE) <input type="checkbox"/> Indigenous <input type="checkbox"/> Out-of-state import <input type="checkbox"/> International import	Linked to imported case (FOR LHD USE) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Import status (FOR STATE USE ONLY) <input type="checkbox"/> Indigenous <input type="checkbox"/> Out-of-state import <input type="checkbox"/> International import	Linked to imported case (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

**CONTACT INVESTIGATION**

Spread setting (check all that apply):

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional Facility	15 <input type="checkbox"/> Other

Number of susceptible contacts \_\_\_\_\_

Close contacts who have rash 8–17 days after exposure to case  
 Yes  No  Unknown

	Name of Case Contact	Rash Onset Date	Relationship	Age (Years)
1		____/____/____		
2		____/____/____		
3		____/____/____		

Please list other contacts on a separate sheet or use the contact tracing work sheet.

<b>CASE CLASSIFICATION (FOR LHD USE)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown	<b>CASE CLASSIFICATION (FOR STATE USE ONLY)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
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**MEASLES CASE CLASSIFICATION**

Clinical Case Definition: An illness characterized by all the following: a generalized rash lasting greater than or equal to 3 days; a temperature greater than or equal to 101.0 °F (greater than or equal to 38.3 °C); cough, coryza, or conjunctivitis  
 Laboratory criteria for diagnosis – positive serologic test for measles immunoglobulin M antibody, or significant rise in measles antibody level by any standard serologic assay, or isolation of measles virus from a clinical specimen

Case Classification:  
 Suspected: any febrile illness accompanied by rash  
 Probable: a case that meets the clinical case definition, has noncontributory or no serologic or virologic testing, and is not epidemiologically linked to a confirmed case  
 Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed case. A laboratory-confirmed case does not need to meet the clinical case definition.