PAHO Pan American Health Organization | World Health Organization Americas Region

Notification and Investigation Form: Measles and Rubella

Complete this form for any patient who a health worker suspects has measles or rubella or who has a fever and maculopapular rash. During the first contact with the patient, the health worker should make every effort to obtain their epidemiologic and clinical data, a blood sample, and at least one sample for viral detection[1], as this may be the only contact with the patient.

Initial diagnosis: ○ Measles ○ Rubella ○ Dengue ○ Zika ○ Chikungunya ○ Other febrile-rash disease, specify: _____ ○ Other

I INFORMATION OF THE REPORTING INSTITUTION

Case number: _____

Country: _____

Subnational level*: _____

Municipality: _____

Name of the reporting institution: _____

Type of reporting institution:
○ Public
○ Private
○ Other, specify: _____

(*) Region, department, province or its equivalent.

Telephone or e-mail of the person reporting: _____

Date of consultation: / / (Day Month Year)

Date of local report: / / (Day Month Year)

Date of investigation or home visit: / / (Day Month Year)

Date of national report: / / (Day Month Year)

Detected by:
○ Health Service ○ Laboratory ○ Institutional active search
○ Community active search ○ Laboratory active search
○ Contact investigation ○ Case reported by the community
○ Self-report via toll-free number: ○ Other, specify: _____

II PATIENT INFORMATION

Patient's first and last names: _____

ID number: _____

Type of identification:
○ Social Security Number ○ Birth Certificate ○ Passport
○ Residence card ○ National Identification Number ○ Other, please specify:

_____

Date of birth: / / (Day Month Year)
If date of birth is unknown, then age: Years: __ Months: __

Sex of patient: ○ Male ○ Female ○ Other: _____

Name of parent or guardian: _____

Home address: _____

_____

Municipality of residence:

_____

Phone: _____

III VACCINATION HISTORY

Is the patient vaccinated?
○ Yes ○ No ○ Unknown
If the vaccinating institution is known, please specify:

Source of vaccination information:
○ Electronic immunization registry ○ Vaccination card
○ Health care facility ○ Verbal ○ Unknown

Type of vaccine[a]	Number of doses	Date of last dose	**If the vaccinating institution is known, please specify:**
		/ / (Day Month Year)	

IV CLINICAL DATA

Fever?
○ Yes ○ No ○ Unknown

Date of fever onset: / / (Day Month Year)

Rash?
○ Yes ○ No ○ Unknown

Type of rash:
○ Maculopapular ○ Other ○ Unknown

Date of rash onset: / / (Day Month Year)

Cough?
○ Yes ○ No ○ Unknown

Conjunctivitis?
○ Yes ○ No ○ Unknown

Coryza?
○ Yes ○ No ○ Unknown

Koplik Spots?
○ Yes ○ No ○ Unknown

Arthralgia?
○ Yes ○ No ○ Unknown

Lymphadenopathy?
○ Yes ○ No ○ Unknown

What complications does the patient have or did the patient have?
○ Pneumonia ○ Encephalitis ○ Diarrhea ○ Thrombocytopenia ○ Acute otitis media ○ Blindness ○ No complications ○ Other, please specify:

Is the patient pregnant?
○ Yes ○ No ○ Unknown

Number of weeks in pregnancy: _____

Is or was the patient hospitalized?
○ Yes ○ No

Name of hospital: _____

Date of hospitalization: / / (Day Month Year)

[1]Collect a respiratory sample up to **14 days** or urine sample up to **10 days** from the date of rash onset of the suspected case.

[a] ○ MMR– Measles-Mumps-Rubella ○ MR– Measles-Rubella ○ MMRV– Measles-Mumps-Rubella-Varicella ○ Other, specify: _____

Was the patient in isolation? ○ Yes ○ No ○ Unknown

Isolation start date: / / (Day Month Year)

Date of termination of isolation: / / (Day Month Year)

Was/Were sample(s) obtained for laboratory diagnosis?
○ Yes ○ No ○ Unknown

V LABORATORY

Specimen			Laboratory test							
Specimen number	Type of specimen**	Date specimen taken	Name of processing laboratory	Date specimen sent to laboratory	Date received	Laboratory sample ID #	Antigen †	Type of test Δ	Results §	Date of results
		/ / Day Month Year			/ / Day Month Year					/ / Day Month Year
		/ / Day Month Year			/ / Day Month Year					/ / Day Month Year

(*) 1) First sample, 2) Second sample, 3) Third sample, 4) Fourth sample, **1) Serum, 2) Pharyngeal or nasopharyngeal aspirate or swab, 3) Urine, 4) Tissue
(†) 1) Measles, 2) Rubella, 88) Other (e.g., Dengue).
(Δ) 1) IgM, 2) IgG, 3) RT-PCR, 4) IgG Avidity, 5) Sequencing

VI FIELD INVESTIGATION

Was active institutional case-finding conducted?
○ Yes ○ No ○ Unknown

Number of suspected cases identified during active institutional case-finding: _____

Was active community case-finding conducted?
○ Yes ○ No ○ Unknown

Number of suspected cases identified during active community case-finding: _____

Are there confirmed measles or rubella cases in the municipality of residence?
○ Yes ○ No ○ Unknown

Was the patient in contact with any pregnant women?
○ Yes ○ No ○ Unknown

Did the patient travel outside his/her state or province of residence in the 7-23 days prior to rash onset?
○ Yes ○ No ○ Unknown

If the patient traveled:
Date of arrival: / / (Day Month Year)
Date of departure: / / (Day Month Year)
Country/city: _____

Setting where infected?
○ Household contact ○ Community ○ Health Service ○ Massive public event ○ Educational Institution
○ International transportation space ○ Public area ○ Unknown ○ Other, specify: _____

VII RESPONSE MEASURES

Was ring vaccination done?
○ Yes ○ No ○ Unknown

Was vitamin A administered?[a]
○ Yes ○ No ○ Unknown

Was rapid vaccination monitoring done?
○ Yes ○ No ○ Unknown

Number of vitamin A doses received[b]: _____

[a] Only for confirmed measles cases [b] 1,2,3, 4= 4 or more, 99= Unknown

VIII CLASSIFICATION

Final classification:
○ Measles ○ Rubella ○ Discarded
○ Does not meet the case definition
○ Pending

Confirmation criteria:
○ Laboratory ○ Epidemiological link
○ Clinical

Criteria to rule out:
○ IgM-negative measles/rubella ○ Vaccine-related
○ Dengue ○ Parvovirus B19 ○ Herpes 6
○ Allergic reaction ○ Other diagnosis, specify: _____

Source of infection of confirmed cases:
○ Imported ○ Import-related ○ Unknown source ○ Endemic

Country of importation: _____

Contact from another case:
○ Yes ○ No ○ Unknown

Case ID of the associated case: _____

Status at the time of discharge:
○ Recovered ○ Deceased ○ Other: _____ ○ Unknown

If deceased, date of death: / / (Day Month Year)
Cause of death: _____

Classified by:
○ National Immunization Program ○ Director of Epidemiological Surveillance
○ Analysis Unit ○ Committee of Experts

Date of final classification: / / (Day Month Year)