SURVEILLANCE OF MEASLES – CASE INVESTIGATION FORM

EPIDEMIOLOGY UNIT MINISTRY OF HEALTH

The MOH should do the investigation personally. Necessary data should be obtained from the hospital by reference to the BHT/Physician or from the diagnosis card. Early investigation and return is essential.

Week ending of Notification	☐☐ ☐☐ ☐☐ d d m m y y	Date of Confirmation	☐☐ ☐☐ ☐☐ d d m m y y	ID Register No : Mea /☐☐☐/☐☐☐☐

A. PARTICULARS OF PATIENT *(Please (✓) appropriate box where applicable)*

1. Name of patient (BLOCK LETTERS) ....

2. Residential Address: ....

Contact Number : .... email : ....

3. Date of Birth : ☐☐/ ☐☐ / ☐☐☐☐ (dd/mm/yy)

4. Age	5. Sex	6. Ethnic group	7. Occupation	8. RDHS area	9. MOH area
☐☐/☐☐ y y / m m	☐ 1. Male ☐ 2. Female	☐ 1. Sinhalese ☐ 2. Tamil ☐ 3. Moor ☐ 4. Others ☐ 9. Unknown	....	....	....

B. PRESENT ILLNESS /OUTCOME

10. (a) Date of onset of fever

☐☐ ☐☐ ☐☐
d d m m y y

(b) Date of onset of rash

☐☐ ☐☐ ☐☐
d d m m y y

11. (a) Did the patient seek medical advice 1. Yes ☐ 2. No ☐

(b) If "Yes" where did the patient first seek medical advice ?

☐ 1. Government hospital
☐ 2. Private hospital
☐ 3. Private practitioner
☐ 4. Ayurvedic institution (public/private)
☐ 5. Other (specify)
....

12. Was patient admitted to hospital?

☐ 1. Yes (If "Yes" question 13)
☐ 2. No (If "No" skip to question 17)

13. If yes, date of admission:

☐☐ ☐☐ ☐☐
d d m m y y

14. Name of hospital: …………………………

15. Ward : …………

16. BHT No:…………..

17. Outcome of the case

☐ 1. Cured
☐ 2. Died
☐ 3. Complication

18. Date of discharge, transfer or death

☐☐ ☐☐ ☐☐
d d m m y y

19. If transferred name of hospital

………………………………………

20. Was patient transferred from some other hospital

1. Yes ☐
2. No ☐

21. If "Yes", where was the patient transferred from ?

………………………………………

C. CLINICAL DATA

Case definition: fever and maculopapular rash with one of cough, coryza (runny nose) or conjunctivitis

22. Symptoms and signs	Yes	No
1. fever	☐	☐
2. masculopapular rash	☐	☐
3. cough	☐	☐
4. coryza	☐	☐
5. conjunctivitis	☐	☐
6. other (Specify)	....	

23. Complications	Yes	No
1. none	☐	■
2. diarrhoea	☐	☐
3. pneumonia	☐	☐
4. otitis media	☐	☐
5. encephalitis	☐	☐
6. other (specify)	....	

D. LABORATORY FINDINGS

24. Was blood taken for measles serology (measles IgM) ? 1. Yes ☐ 2. No ☐

(a) If yes: 1. Hospital ☐ 2. Private Practitioner ☐ 3. MOH ☐ 4. Other ☐

(b)

Investigation (Serology) e.g. IgM / IgG	Date of collection of specimen (dd/mm/yy)	Date of sent to laboratory	Laboratory (MRI/govt./private)	Results (mark NA if test results are not available)	Date of results

25. Was samples collected for virus isolation 1. Yes ☐ 2. No. ☐

If yes:

Sample type	Date of collection	Date of sent	Name of the laboratory	Date of result	Results		
					+ve	–ve	Geno type
☐ (i) swabs (throat/nasal gingival) ☐ (ii) secretion (nasal/oral) ☐ (iii) urine ☐ (iv) other							

E. MEASLES VACCINATION STATUS

26. Was Measles Containing Vaccine given (MCV) [Measles, MR, MMR]

1. Yes ☐ 2. No ☐ 3. Not known ☐

27. If "yes" (a) Number of doses 1 ☐ 2 ☐ >2 ☐

(b) source of information Vaccination card ☐ History: ☐

details of immunization

Dose	Date of immunization (dd/mm/yy)	Type of vaccine Measles, MR, MMR	Batch number	Place of immunization*
1st dose				
2nd dose				
Other				

*MOH office / Immunization clinic / Govt. Hospital / Private Hospital / General Practitioner / Not known / Other

F. CONTACT HISTORY

28. Has the patient been in contact with anyone with fever and/or rash within **3 weeks prior to onset of illness** ?

1. Yes ☐ 2. No ☐ 3. Not known ☐
(if yes, fill row 1 – 3 with details)

Details of the patient's household or other close contacts who developed a similar illness **following the development of measles in the patient**, and their immunization status (fill Row 4 – 7 with details)

		Name	Age	Sex	Date of onset of rash	Relationship to patient	Vaccinated for MCV		
							Yes	No	Not known
28a. contacts with a similar disease prior to onset of illness in the patient	1								
	2								
	3								
28b. contacts who developed similar illness after contact of the index patient	4								
	5								
	6								
	7								

29. Is the patient having a history of travel abroad (3 weeks prior to illness onset) ☐ Yes ☐ No

If yes : (i) Country of travel : ....

(ii) History of Measles contact in abroad ☐ Yes ☐ No ☐ Not known

Remarks
....
....
....

Signature: .... Name:...

Date: .... Designation:..

Please return to:
Epidemiologist, Epidemiology Unit, 231, De Saram Place, Colombo 10
email: epidunit@sltnet.lk Tel: 011-2695112 / 2681548 Fax: 011-2696583

FOR OFFICE USE ONLY

Final classification

☐ 1. Laboratory confirmed
☐ 2. Epidemiologically confirmed
☐ 3. Clinically confirmed
☐ 4. Non Measles case (discarded)