SURVEILLANCE OF MEASLES – CASE INVESTIGATION FORM

EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH

The MOH or PHI 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 are essential.

Week ending of notification ☐☐ ☐☐ ☐☐ (d d m m y y)	Serial no: ☐☐☐☐	Please write the Serial No given in the Infectious Disease Register (ID Register) in the MOH office

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

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

2. Residential address: ....

3. Date of birth: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)

4. Age	5. Sex	6. Ethnic group	7. Occupation	8. DPDHS division (district)	9. MOH area
☐☐/☐☐ y y / m m	☐ 1. male ☐ 2. female ☐ 3. not known	☐ 1. Sinhalese ☐ 2. Tamil ☐ 3. Moor ☐ 4. others ☐ 5. not known	....	....	....
			FOR OFFICE USE ONLY		
			☐☐	☐☐	☐☐

B. PRESENT ILLNESS/OUTCOME

10. Date of onset of symptoms: ☐☐ ☐☐ ☐☐ (d d m m y y)

11. 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 → to Q. 13
- ☐ 2. no } skip to Q. 21
- ☐ 3. not known } skip to Q. 21

13. If yes, date of admission: ☐☐ ☐☐ ☐☐ (d d m m y y)

14. Name of hospital: ....

15. Ward: ....

16. BHT no: ....

17. Date of discharge/transfer or death: ☐☐ ☐☐ ☐☐ (d d m m y y)

18. If transferred, name of hospital

....

19. Was patient transferred from some other hospital?
☐ 1. yes ☐ 2. no

20. If “yes”, where was the patient transferred from?

....

21. Outcome of the case
- ☐ 1. cured ☐ 3. transferred
- ☐ 2. died ☐ 4. not known

C. CLINICAL DATA

Case definition: any person with fever with maculopapular rash (>3 days) and cough, coryza (runny nose) or conjunctivitis

22. Symptoms and signs
- ☐ 1. fever
- ☐ 2. generalized rash
- ☐ 3. cough
- ☐ 4. coryza
- ☐ 5. conjunctivitis
- ☐ 6. other (specify): ....

23. Complications
- ☐ 1. none
- ☐ 2. diarrhoea
- ☐ 3. pneumonia
- ☐ 4. otitis media
- ☐ 5. encephalitis
- ☐ 6. other (specify): ....

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Compatible with the case definition:
- ☐ 1. Yes
- ☐ 2. No

D. LABORATORY FINDINGS

24. Was blood taken for measles serology? ☐ 1. yes ☐ 2. no. ☐ 3. not known

25. If yes:

Investigation	Date of collection of specimen (dd/mm/yy)	Laboratory (MRI/govt./private)	Results (mark NA if test results are not available and PP if pending)
1. IgG 1st specimen			
2. IgG 2nd specimen			
3. IgM			
4. Virus isolation			

E. MEASLES VACCINATION STATUS

26. Was measles vaccine given before the onset of the present illness?

☐ 1. yes ☐ 2. no ☐ 3. not known

27. If yes, details of immunization:

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

*If the date is not known but the particular dose has been given, mark (✓) in the relevant cage
** Measles vaccine/ MR vaccine/ MMR vaccine/ not known
***MOH office/ govt. hospital/ PHM field clinic/ private hosp/clinic/GP/ 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)

29. 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 measles		
							yes	no	not known
28a. contacts with a similar disease prior to onset of illness in the patient	1								
	2								
	3								
29a. contacts of the patient who developed similar illness after the development of measles in the patient	4								
	5								
	6								
	7								

30. Remarks:

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....

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....

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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

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Final classification

Laboratory confirmed ☐

Epidemiologically confirmed ☐

Clinically confirmed ☐