

CASE REPORT FORM

Measles, Mumps, Rubella

Measles Mumps Rubella		EpiSurv No. _____	
Disease Name			
<input type="radio"/> Measles		<input type="radio"/> Mumps	
<input type="radio"/> Rubella			
Reporting Authority			
Name of Public Health Officer responsible for case _____			
Notifier Identification			
Reporting source*		<input type="radio"/> General Practitioner	
		<input type="radio"/> Hospital-based Practitioner	
		<input type="radio"/> Laboratory	
		<input type="radio"/> Self-notification	
		<input type="radio"/> Outbreak Investigation	
		<input type="radio"/> Other	
Name of reporting source _____		Organisation _____	
Date reported* _____		Contact phone _____	
Usual GP _____		Practice _____	
		GP phone _____	
GP/Practice address		Number _____ Street _____ Suburb _____	
		Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____	
Case Identification			
Name of case*		Surname _____ Given Name(s) _____	
NHI number* _____		Email _____	
Current address*		Number _____ Street _____ Suburb _____	
		Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____	
Phone (home) _____		Phone (work) _____	
		Phone (other) _____	
Case Demography			
Location TA* _____		DHB* _____	
Date of birth* _____		OR Age _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	
Sex*		<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown	
Occupation* _____			
Occupation location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address		Number _____ Street _____ Suburb _____	
		Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____	
Alternative location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address		Number _____ Street _____ Suburb _____	
		Town/City _____ Post Code _____ <input type="checkbox"/> GeoCode _____	
Ethnic group case belongs to* (tick all that apply)			
<input type="checkbox"/> NZ European		<input type="checkbox"/> Maori	
		<input type="checkbox"/> Samoan	
		<input type="checkbox"/> Cook Island Maori	
<input type="checkbox"/> Niuean		<input type="checkbox"/> Chinese	
		<input type="checkbox"/> Indian	
		<input type="checkbox"/> Tongan	
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)		*(specify) _____	

Basis of Diagnosis**CLINICAL CRITERIA****Fits Clinical Description*** Yes No Unknown**Measles**Fever ≥ 38.0 ° C present at time of rash onset Yes No Unknown

Maculopapular rash

 Yes No Unknown

If yes, date of onset of rash* _____

Cough

 Yes No Unknown

Coryza

 Yes No Unknown

Conjunctivitis

 Yes No Unknown

Koplik's spots

 Yes No Unknown**Mumps**

Acute swelling of parotid or other salivary gland for more than 2 days

 Yes No Unknown

Orchitis

 Yes No Unknown**Rubella**

Fever

 Yes No Unknown

Maculopapular rash

 Yes No Unknown

If yes, date of onset of rash* _____

Arthritis/arthralgia

 Yes No Unknown

Lymphadenopathy

 Yes No Unknown

Conjunctivitis

 Yes No Unknown**LABORATORY CRITERIA****Laboratory confirmation of disease*** Yes No Not Done Awaiting Results**Confirmation method** Isolation of virus from clinical specimen Positive IgM antibody Significant rise in IgG antibody level Nucleic acid testing (NAT/PCR) Genetic characterisation (specify strain) _____**EPIDEMIOLOGICAL CRITERIA****Contact with a confirmed case*** Yes No Unknown

If yes, specify the EpiSurv number of the confirmed case* _____

CLASSIFICATION* Under investigation Probable Confirmed Not a case**Clinical Course and Outcome****Date of onset***

 Approximate Unknown**Hospitalised*** Yes No Unknown**Date hospitalised***

 Unknown**Hospital***

Died* Yes No Unknown**Date died***

 Unknown**Was this disease the primary cause of death?*** Yes No Unknown

If no, specify the primary cause of death* _____

Outbreak Details**Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*** Yes**If yes, specify Outbreak No.*** _____**Risk Factors****Contact with another case of the disease during the incubation period for this disease*** Yes No Unknown**Attendance at school, pre-school or childcare during the incubation period for this disease*** Yes No Unknown**Was the case overseas during the incubation period for this disease?*** Yes No Unknown

If yes, date arrived in New Zealand* _____

Specify countries visited* (from most recent to least recent)

Country/Region*

Date Entered*

Date Departed*

Last* _____

Second Last* _____

Third Last* _____

Other risk factors for measles, mumps or rubella (specify)* _____**Source (measles and rubella only)****What was the source of the virus?*** Imported Import-related Endemic Unknown

If imported, specify country* _____

Specify region /city* _____

If import-related, specify the EpiSurv number of the source case* _____

If the case was infected in New Zealand, specify the DHB where contact occurred* _____

Protective Factors**At any time prior to onset, had the case been immunised with the MMR or appropriate monovalent vaccine?*** Yes No Unknown

If yes specify, vaccine details*

First administered dose:*

 MMR/Monovalent Unknown

Date given* _____

Or age when first dose was given _____

 Weeks Months Years

Source of information*

 Patient/caregiver recall Documented

Second administered dose:*

 MMR/Monovalent Not given Unknown

Date given* _____

Or age when second dose was given _____

 Weeks Months Years

Source of information*

 Patient/caregiver recall Documented**Management****CASE MANAGEMENT****Date case investigation was started* (measles and rubella only)** _____**Date case investigation was completed* (measles and rubella only)** _____**Case excluded from work or school/pre-school/childcare for appropriate period*** Yes No NA Unknown**Was case pregnant (rubella only)?*** Yes No Unknown

If yes, gestation period* _____ (weeks) at time of onset

Management

CONTACT MANAGEMENT

Did the case have any contacts (measles and rubella only)?* Yes No Unknown

If yes, specify number and management*

Category	Number identified	Number susceptible	Number given MMR (measles only)	Number declined MMR (measles only)	Number given IG (measles only)
<15 months of age	_____	_____	_____	_____	_____
15 months and over (not pregnant)	_____	_____	_____	_____	_____
Pregnant	_____	_____	_____	_____	_____

Flight details if case infectious while on board an international flight (measles only)*

	Last flight	2nd to last flight	3rd to last flight	4th to last flight
Flight number(s)	_____	_____	_____	_____
Date of departure	_____	_____	_____	_____

Unimmunised susceptibles excluded from school/pre-school/childcare for appropriate period* Yes No NA Unknown

Comments*