

# CASE REPORT FORM

# Measles, Mumps, Rubella

Measles Mumps Rubella		EpiSurv No. <u>EpiSurvNumber</u>	
<b>Disease Name</b>			
<input type="radio"/> Measles		<input type="radio"/> Mumps	
		<input type="radio"/> Rubella	
<b>Reporting Authority</b>			
Name of Public Health Officer responsible for case <b>OfficerName</b> _____			
<b>Notifier Identification</b>			
<b>Reporting source*</b> <b>ReportSrc</b>		<b>ReportOrganisation</b>	
<input type="radio"/> General Practitioner		<input type="radio"/> Hospital-based Practitioner	
<input type="radio"/> Self-notification		<input type="radio"/> Outbreak Investigation	
		<input type="radio"/> Laboratory	
		<input type="radio"/> Other	
Name of reporting source <b>ReportName</b> _____		Organisation <b>ReportOrganisation</b> _____	
Date reported* <b>ReportDate</b> _____		Contact phone <b>ReportPhone</b> _____	
Usual GP <b>UsualGP</b> _____		Practice <b>GPPracticeName</b> _____	
		GP phone <b>GPPhone</b> _____	
<b>GP/Practice address</b> Number _____ Street _____ Suburb _____			
<b>GPAddress</b> Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
<b>Case Identification</b>			
<b>Name of case*</b> Surname <b>Surname</b> _____		Given Name(s) <b>GivenName</b> _____	
<b>NHI number*</b> <b>NHINumber</b> _____		<b>Email</b> <b>Email</b> _____	
<b>Current address*</b> Number _____ Street _____ Suburb _____			
<b>CaseAddress</b> Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
<b>Phone (home)</b> <b>PhoneHome</b> _____		<b>Phone (work)</b> <b>PhoneWork</b> _____	
		<b>Phone (other)</b> <b>PhoneOther</b> _____	
<b>Case Demography</b>			
<b>Location</b> <b>TA* TA</b> _____		<b>DHB* DHB</b> _____	
<b>Date of birth*</b> <b>DateOfBirth</b> _____		<b>OR</b> <b>Age</b> <b>Age</b> _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years <b>AgeUnits</b>	
<b>Sex*</b> <b>Sex</b> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown			
<b>Occupation*</b> <b>Occupation</b> _____			
<b>Occupation location</b> <b>PlaceOfWork1Type</b> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
<b>Name</b> <b>PlaceOfWork1</b> _____			
<b>Address</b> Number _____ Street _____ Suburb _____			
<b>PlaceOfWork1Address</b> Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
<b>Alternative location</b> <b>PlaceOfWork2Type</b> <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
<b>Name</b> _____			
<b>Address</b> Number _____ Street _____ Suburb _____			
<b>PlaceOfWork2Address</b> Town/City _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
<b>Ethnic group case belongs to*</b> (tick all that apply)			
<input type="checkbox"/> NZ European <b>EthNZEuroean</b>		<input type="checkbox"/> Maori <b>EthMaori</b>	
		<input type="checkbox"/> Samoan <b>EthSamoan</b>	
		<input type="checkbox"/> Cook Island Maori <b>EthCookIslandMaori</b>	
<input type="checkbox"/> Niuean <b>EthNiuean</b>		<input type="checkbox"/> Chinese <b>EthChinese</b>	
		<input type="checkbox"/> Indian <b>EthIndian</b>	
		<input type="checkbox"/> Tongan <b>EthTongan</b>	
<input type="checkbox"/> Other (such as Dutch, Japanese) <b>EthOther</b>		*(specify) <b>EthSpecify1</b> _____ <b>EthSpecify2</b> _____	

**Basis of Diagnosis****CLINICAL CRITERIA**

<b>Fits Clinical Description*</b> <b>FitClinDes</b>		<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
<b>Measles</b>	Fever $\geq 38.0$ ° C present at time of rash onset <b>MeaslesFever</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Maculopapular rash <b>MeaslesRash</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	If yes, date of onset of rash* <b>MeaslesRashDate</b> _____			
	Cough <b>Coughing</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Coryza <b>Coryza</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Conjunctivitis <b>MeaslesConjunctivitis</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Koplik's spots <b>KopliksSpots</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
<b>Mumps</b>	Acute swelling of parotid or other salivary gland for 2 or more days <b>AcuteSwell</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Orchitis <b>Orchitis</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
<b>Rubella</b>	Fever <b>RubellaFever</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Maculopapular rash <b>RubellaRash</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	If yes, date of onset of rash* <b>RubellaRashDate</b> _____			
	Arthritis/arthralgia <b>Arthritis</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Lymphadenopathy <b>Lymphad</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
	Conjunctivitis <b>RubellaConjunctivitis</b>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown

**LABORATORY CRITERIA**

**Laboratory confirmation of disease\*** **LabConf**  Yes  No  Not Done  Awaiting Results

**Confirmation method**

- Isolation of virus from clinical specimen **ConfIsolation**  Positive IgM antibody **ConfIgM**  Significant rise in IgG antibody level **ConfIgG**  
 Nucleic acid testing (NAT) **ConfNAT**  Genetic characterisation (specify) **ConfGenC** **ConfGenCSpec**

**EPIDEMIOLOGICAL CRITERIA**

**Contact with a confirmed case\*** **ConfCase**  Yes  No  Unknown

If yes, specify the EpiSurv number of the confirmed case\* **ConfEpiSurvNo** \_\_\_\_\_

**CLASSIFICATION\*** **Status**  Under investigation  Probable  Confirmed  Not a case

**Clinical Course and Outcome**

**Date of onset\*** **OnsetDt** \_\_\_\_\_  Approximate **OnsetDtApprox**  Unknown **OnsetDtUnknown**

**Hospitalised\*** **Hosp**  Yes  No  Unknown

**Date hospitalised\*** **HospDt** \_\_\_\_\_  Unknown **HospDtUnknown**

**Hospital\*** **HospName** \_\_\_\_\_

**Died\*** **Died**  Yes  No  Unknown

**Date died\*** **DiedDt** \_\_\_\_\_  Unknown **DiedDtUnknown**

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

If no, specify the primary cause of death\* **DiedOther** \_\_\_\_\_

**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 **Outbrk**If yes, specify Outbreak No.\* **OutbrkNo** \_\_\_\_\_**Risk Factors**Contact with another case of the disease during the incubation period for this disease\* **ContPrev**  Yes  No  UnknownAttendance at school, pre-school or childcare during the incubation period for this disease\* **AttendSch**  Yes  No  Unknown

Was the case overseas during the incubation period for this disease?\*

**Overseas**If yes, date arrived in New Zealand\* **DtArrived** \_\_\_\_\_

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

	Country/Region*	Date Entered*	Date Departed*
Last*	<b>LastCountry</b> _____	<b>LastDtEntered</b> _____	<b>LastDtDearded</b> _____
Second Last*	<b>SecCountry</b> _____	<b>SecDtEntered</b> _____	<b>SecDtDeparted</b> _____
Third Last*	<b>ThirdCountry</b> _____	<b>ThirdDtEntered</b> _____	<b>ThirdDtDeparted</b> _____

Other risk factors for measles, mumps or rubella (specify)\* **OtherRisk** \_\_\_\_\_**Source (measles and rubella only)**

What was the source of the virus?\*

**Source** Imported Import-related Endemic UnknownIf imported, specify country\* **ImptCountry** \_\_\_\_\_Specify region /city\* **ImptRegion** \_\_\_\_\_If import-related, specify the EpiSurv number of the source case\* **SceEpiSurvNo** \_\_\_\_\_If the case was infected in New Zealand, specify the DHB where contact occurred\* **SourceDHB** \_\_\_\_\_**Protective Factors**

At any time prior to onset, had the case been immunised with the MMR or appropriate monovalent vaccine?\*

**Immunised** Yes No Unknown

If yes specify, vaccine details\*

First administered dose:\* **FirstDose**  MMR/Monovalent  UnknownDate given\* \_\_\_\_\_ Or age when first dose was given **YMWFirstDose**  Weeks  Months  Years**DtFirstDose** \_\_\_\_\_**AgeFirstDose** \_\_\_\_\_Source of information\* **SceFirstDose**  Patient/caregiver recall  DocumentedSecond administered dose:\* **SecndDose**  MMR/Monovalent  Not given  UnknownDate given\* \_\_\_\_\_ Or age when second dose was given **YMWSecndDose**  Weeks  Months  Years**DtSecndDose** \_\_\_\_\_**AgeSecndDose** \_\_\_\_\_Source of information\* **SceSecndDose**  Patient/caregiver recall  Documented**Management****CASE MANAGEMENT**

Date case investigation was started\*

(measles and rubella only) **InvStart** \_\_\_\_\_

Date case investigation was completed\*

(measles and rubella only) **InvEnd** \_\_\_\_\_Case excluded from work or school/pre-school/childcare for appropriate period\* **Excluded**  Yes  No  NA  UnknownWas case pregnant (rubella only)?\* **Pregnant**  Yes  No  UnknownIf yes, gestation period\* **Gestation** \_\_\_\_\_ (weeks) at time of onset

**Management****CONTACT MANAGEMENT**

Did the case have any contacts (measles and rubella only)?\* **CaseCont**  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	<b>NoLT15</b> _____	<b>NoLT15Susc</b> _____	<b>NoLT15MMR</b> _____	<b>NoLT15Declined</b> _____	<b>NoLT15IG</b> _____
15 months and over (not pregnant)	<b>NoGE15</b> _____	<b>NoGE15Susc</b> _____	<b>NoGE15MMR</b> _____	<b>NoGE15Declined</b> _____	<b>NoGE15IG</b> _____
Pregnant	<b>NoPreg</b> _____	<b>NoPregSusc</b> _____			<b>NoPregIG</b> _____

**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)	<b>Flight1No</b> _____	<b>Flight2No</b> _____	<b>Flight3No</b> _____	<b>Flight4No</b> _____
Date of departure	<b>Flight1DepDt</b> _____	<b>Flight2DepDt</b> _____	<b>Flight3DepDt</b> _____	<b>Flight4DepDt</b> _____

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

**Comments\***

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