Case name: .... DOB ..../......../........ Notification ID: ....

First name *Surname*

Measles Case Report Form

.... **Public Health Unit** Outbreak ID: ....

Completed by: .... Date sent to NOCS: ..../......../........

Telephone: .... Fax: ....

NOTIFICATION:

Date PHU notified: ..../......../........ Date initial response: ..../......../........

Notifier: .... Organisation: ....

Telephone: .... Fax: .... Email: ....

Treating Dr: ....

Telephone: .... Fax: .... Email: ....

CASE DETAILS: **UR No:** ....

Name: ....

First name *Surname*

Date of birth: ..../......../........ Age: .... Years ....Months Sex: ☐ Male ☐ Female ....

Name of parent/carer: ....

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Non-Indigenous ☐ Unknown

English preferred language: ☐ Yes ☐ No – *specify* .... Ethnicity – *specify* ....

Permanent address: ....

.... Postcode: ....

Home tel: .... Mob: .... Email: ....

Occupation: .... Work telephone: ....

Temporary address in Queensland *(if different from permanent address)* : ....

.... Postcode: ....

Telephone: .... Mob: .... Email: ....

General Practitioner: Dr ....

Address: .... Postcode: ....

Telephone: .... Fax: .... Email: ....

CLINICAL DETAILS: "CbgYh 8UhY. ..../......../........

Date first symptoms: ..../......../........ ☐ Unknown Date of rash: ..../......../........

Site of onset of rash: ☐ Head ☐ Trunk ☐ Extremities ☐ Unknown

Fever: ☐ Yes ☐ No ☐ Unknown At rash onset? ☐ Yes ☐ No ☐ Unknown Measured temperature ..... °C

Cough: ☐ Yes ☐ No ☐ Unknown Conjunctivitis: ☐ Yes ☐ No ☐ Unknown

Coryza: ☐ Yes ☐ No ☐ Unknown Koplik spots: ☐ Yes ☐ No ☐ Unknown

Hospitalised: ☐ Yes ☐ No ☐ Unknown Hospital: .... Date: ..../......../........ to ..../......../........

Complications: ☐ Yes – *specify* .... ☐ No ☐ Unknown

Outcome: ☐ Survived ☐ Died Date of death: ..../......../........ ☐ Died of condition ☐Unknown

Case name: .... DOB ..../......../........ Notification ID: ....
First name *Surname*

LABORATORY: Laboratory: .... First collection date: ..../......../........

Measles PCR positive:	Urine:	☐ Yes	☐ No	☐ Not done	☐ Result pending
	Throat/nasopharyngeal swab:	☐ Yes	☐ No	☐ Not done	☐ Result pending
Measles IgM positive:		☐ Yes	☐ No	☐ Not done	☐ Result pending
Measles IgG seroconversion:		☐ Yes	☐ No	☐ Not done	☐ Result pending

MEASLES VACCINATION DETAILS:

Dose	Date	Type
1	......../......../........	....
2	......../......../........	....

Vaccination status: ☐ Age-appropriate ☐ Incomplete ☐ Not vaccinated ☐ Unknown

Source of vaccination history: ☐ ACIR/VIVAS ☐ Health record ☐ Self reported ☐ Not applicable

EXPOSURE PERIOD:

Date: ..../......../........ to Date: ..../......../........
(Onset of symptoms – 18 days) (Onset of symptoms – 7 days)

Was there contact with another case of measles? ☐ Yes ☐ No ☐ Unknown

Name / NID: .... Telephone: .... Contact type: ....

Name / NID: .... Telephone: .... Contact type: ....

Did case attend any of the following during their exposure period?

☐ Childcare – *specify* .... Telephone: .... Dates attended: ....

☐ Preschool/school – *specify* .... Telephone: .... Dates attended: ....

☐ Educational/residential facility – *specify* .... Telephone: .... Dates attended: ....

☐ Hosp/healthcare facility – *specify* .... Telephone: .... Dates attended: ....

☐ Other risk setting(s) – *specify* ....

Has the case travelled prior to onset? ☐ Yes – *specify*: .... ☐ No ☐ Unknown

PLACE ACQUIRED:

☐ Hospital/healthcare facility

☐ Queensland ☐ Other Australian state/territory – *specify* ....

☐ Unknown ☐ Other country – *specify* ....

Case name: .... DOB ..../......../........ Notification ID: ....
First name Surname

INFECTIOUS PERIOD:

Date: ..../......../........ to Date: ..../......../........
(1 day prior to onset of prodrome symptoms or 4 days prior to rash onset) (Onset of rash + 4 days)

Did case attend any of the following during their infectious period?

☐ Childcare – *specify* .... Telephone: .... Dates attended: ....

☐ Preschool/school – *specify* .... Telephone: .... Dates attended: ....

☐ Educational/residential facility – *specify* .... Telephone: .... Dates attended: ....

☐ Hosp/healthcare facility – *specify* .... Telephone: .... Dates attended: ....

☐ Other risk setting(s) – *specify* ....

Case excluded from childcare/school/other high risk setting: ☐ Yes ☐ No ☐ Unknown Dates: ....

NOTIFICATION DECISION: ☐ Confirmed – Measles case ☐ Probable – Measles case

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CONTACT MANAGEMENT:

Type of contact	Number of contacts	Intervention recommended		
		Vaccine	NHIG	No intervention
Household (including all people sleeping overnight in same room as case)	Children: .... Adults:	....	....	....
Shared a classroom (e.g. child care, family day care, preschool or school)	Children: .... Adults:	....	....	....
Waiting rooms (e.g. GP, ED, Pathology, X-ray room)	Children: .... Adults:	....	....	....
Workplace	Children: .... Adults:	....	....	....
Travel	Children: .... Adults:	....	....	....
Other	Children: .... Adults:	....	....	....

COMMENTS:

Case name: ....
First name *Surname*

DOB ..../......../........

Notification ID: ....

CONTACT DETAILS (PHU use only)

Name	Type of contact	Age/DOB	Telephone	Immune status	Intervention

COMMENTS: