Tennessee Department of Health
Measles Case Report

Demographics

Last Name: ____________________ First: ____________________ Middle: ____________
DOB: / / 
Reported Age: ________ □ Days □ Months □ Years
Sex: □ Male □ Female □ Unknown
Street Address: ________________________________________________________________

City: __________________________ County: __________________________ State: __________ Zip: _____________
Phone - Home: ________________________ Work: _________________________ Cell: ___________
Ethnicity: □ Hispanic □ Not Hispanic Race: □ American Indian / Alaskan □ Asian □ Black / African American
□ Hawaiian / Pacific Islander □ White □ Other (_____________)
Employer/School/Daycare: _____________________________________________________ Occupation: ___________________________

Alternate Contact Information

Last Name: _____________________ First: ____________________ Relationship: □ Parent □ Spouse □ Household Member
Phone #: __________________________ □ Friend □ Other ______________

Investigation Summary

Jurisdiction: □ East Tennessee □ Mid-Cumberland □ Northeast □ South Central □ Southeast
□ West Tennessee □ Upper Cumberland □ Nashville/Davidson □ Chattanooga/Hamilton □ Knox/Knoxville
□ Jackson/Madison □ Memphis/Shelby □ Sullivan □ Out of Tennessee □ Unassigned

INVESTIGATION SUMMARY

Investigation Start Date: / / 
Investigation Status: □ Open □ Closed
Investigator: __________________________________
Date Assigned to Investigation: / / 
Physician: ____________________________________
Physician’s Phone: _____________________________

REPORTING SOURCE

Date of Report: / / 
Reporting Source: ______________________________
Earliest Date Reported to County: / / 
Earliest Date Reported to State: / / 
Reporter: _______________________________

Clinical Information

Was the patient hospitalized for this illness? □ Yes □ No □ Unknown
Hospital: ________________________________________________________________
Admission Date: / / 
Discharge Date: / / 
Diagnosis Date: / / 
Illness Onset Date: / / 
Airborne isolation/infection control recommendations implemented? □ Yes □ No □ Unknown
If yes, describe: __________________________________________________________

Was the patient have a rash? □ Yes □ No □ Unknown
Rash onset Date: / / 
Duration: ___ days
Was the rash generalized? □ Yes □ No □ Unknown
Did patient have a fever? □ Yes □ No □ Unknown
Highest Temperature: _______

Symptoms

Did patient have any of the following symptoms? □ Cough □ Coryza (runny nose) □ Conjunctivitis

(Check all that apply)

□ Croup □ Otitis media □ Diarrhea □ Pneumonia □ Encephalitis
□ Thrombocytopenia □ If other complications, specify_________________

Did the patient develop hepatitis? □ Yes □ No □ Unknown

Did the patient die from measles or complications (including secondary infection) associated with measles? □ Yes □ No □ Unknown

Comments

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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________________________________________________________________________
LABORATORY

Was laboratory testing done for measles? □ Yes □ No □ Unknown  (If yes, complete the table below.)

<table>
<thead>
<tr>
<th></th>
<th>IgM Serum</th>
<th>Acute IgG Serum</th>
<th>Convalescent IgG Serum</th>
<th>Other Lab Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was testing performed?</td>
<td>□ Yes □ No □ Unknown</td>
<td>□ Yes □ No □ Unknown</td>
<td>□ Yes □ No □ Unknown</td>
<td>□ Yes □ No □ Unknown</td>
</tr>
</tbody>
</table>

Name of Laboratory

Date Specimen Taken

Result of Test

□ Negative □ Positive □ Pending □ Indeterminate □ Unknown □ No significant rise in IgG □ Significant rise in IgG □ Indeterminate □ Unknown

Were the clinical specimens sent to CDC for genotyping (molecular typing)? □ Yes □ No □ Unknown

Date sent for genotyping: ______/_____/______

Specimen Type: ________________________________

Was the (measles) virus genotype sequenced? □ Yes □ No □ Unknown

If yes, identify the genotype: □ A □ B2 □ B3 □ C1 □ C2 □ D2 □ D3 □ D4 □ D5 □ D6 □ D7 □ D8 □ D9 □ D10 □ G2 □ G3 □ H1 □ H2 □ Unknown □ Other: ________________________________

Specimen type: ________________________________

VACCINATION

Did the patient receive measles containing vaccine? □ Yes □ No □ Unknown

Number of doses received BEFORE 1st birthday: ______

Number of doses received ON or AFTER 1st birthday: ______

If vaccinated BEFORE first birthday, but not doses given ON or AFTER first birthday, what is the reason? (enter # from below)

If patient received one dose ON or AFTER first birthday, but never received a second dose after the first birthday, what is the reason? (enter # from below)

Reason:
1- Born outside of US
2- Laboratory evidence of previous disease
3- MD diagnosis of previous disease
4- Medical Contraindication
5- Parent/Patient forgot to vaccinate
6- Parent/Patient refusal
7- Parent/Patient report of disease
8- Philosophical objection
9- Religious exemption
10- Underage for vaccination
11- Unknown

Dates of each MMR vaccination: 1 _____/_____/______ 2 _____/_____/______ □ Dates Unknown

EPIDEMIOLOGIC INFORMATION

Does this patient reside in the USA? □ Yes □ No □ Unknown

Length of time in the United States (in years): ____________

Country of birth: ________________________________

Is this case epi-linked to another confirmed or probable case? □ Yes □ No □ Unknown

What was the transmission setting (use number from choices)?

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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1- Athletics</td>
<td>2- College</td>
<td>3- Community</td>
<td>4- Correctional facility</td>
</tr>
<tr>
<td>5- Day Care</td>
<td>6- Doctor’s office</td>
<td>7- Home</td>
<td>8- Hospital ER</td>
</tr>
<tr>
<td>9- Hospital outpatient clinic</td>
<td>10- Hospital ward</td>
<td>11- International travel</td>
<td>12- Military</td>
</tr>
<tr>
<td>13- Church</td>
<td>14- School</td>
<td>15- Unknown</td>
<td>16- Work</td>
</tr>
<tr>
<td>17- Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Were age and setting verified? □ Yes □ No □ Unknown

COMMENTS

________________________________________________________

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**EPIDEMILOGIC INFORMATION (CONTINUED)**

<table>
<thead>
<tr>
<th>CASE ID#: ____________________________________________</th>
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</table>

Is this case part of an outbreak of 3 or more cases?: □ Yes □ No □ Unknown  **If yes, outbreak name:** __________________________

Source of infection (i.e. person ID, country, ...): __________________________________________

Did rash onset occur within 18 days of entering the US, following any travel or living outside the US? □ Yes □ No □ Unknown

Is this case traceable (linked) to an international import? □ Yes □ No □ Unknown

Where was the disease acquired?: □ Indigenous (within jurisdiction) □ Out of country □ Out of state □ Out of jurisdiction □ Unknown

Imported Country: ____________________________  Imported State: ____________________________

Imported City: ____________________________  Imported County: ____________________________

**CONTACT INFORMATION**

<table>
<thead>
<tr>
<th>Index Case Name:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>In the US</td>
<td></td>
</tr>
<tr>
<td>In another US state</td>
<td></td>
</tr>
<tr>
<td>Out of US</td>
<td></td>
</tr>
</tbody>
</table>

Confirmation Method: □ Clinical Diagnosis □ Epidemiologically-linked □ Lab Confirmed □ Other (__________________)  

Case Status: □ Confirmed □ Suspect □ Probable

**COMMENTS**

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

**FOR ADMINISTRATIVE USE ONLY:**

Date of Interview: _____/_____/_______  Was the case entered into NEDSS? □ Yes □ No □ Unknown

Interviewer’s Name: ____________________________________________  Date entered into NEDSS: _____/_____/_______

Other Notes: ____________________________________________  Data Entry Person’s Name: ____________________________