State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Immunization Branch
850 Marina Bay Parkway Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403
Fax: (510) 620-3949

MEASLES CASE REPORT FORM

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

Census Tract	County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information

Work / School Location	Work / School Contact

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	If Yes, Est. Delivery Date (mm/dd/yyyy)

Medical Record Number	Patient's Parent/Guardian Name

Occupation Setting	Other Describe/Specify

Occupation	Other Describe/Specify

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 8)
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.
☐ American Indian or Alaska Native
☐ Asian (check all that apply, see list on page 8)
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
(check all that apply, see list on page 8)
- ☐ Native Hawaiian
- ☐ Fijian
- ☐ Guamanian
- ☐ Samoan
- ☐ Tongan
- ☐ Other: _____

☐ White
☐ Other: _____
☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

SIGNS AND SYMPTOMS

Rash ☐ Yes ☐ No ☐Unknown	Rash Onset Date (mm/dd/yyyy)	Rash Duration (Days)		
Generalized Rash ☐ Yes ☐ No ☐Unknown	Origin on Body	Direction of Spread		
Fever ☐ Yes ☐ No ☐Unknown	Fever Onset Date (mm/dd/yyyy)	Was temperature >101F (38.3C) ☐ Yes ☐ No ☐ Unknown	If Yes, highest temperature (specify F/C)	If temperature not taken, skin was: ☐ Hot ☐ Warm ☐ Normal ☐ Unknown

Cough ☐ Yes ☐ No ☐Unknown	Runny Nose (Coryza) ☐ Yes ☐ No ☐Unknown	Conjunctivitis ☐ Yes ☐ No ☐Unknown	Koplik's Spots ☐ Yes ☐ No ☐Unknown
Diagnosis Date (mm/dd/yyyy)			
If Other Symptoms, describe:			

HOSPITALIZATION

Hospitalized? ☐ Yes ☐ No ☐ Unknown	Days Hospitalized		
ICU Admission ☐ Yes ☐ No ☐ Unknown			
Hospital Name	Street Address		
City	State	ZIP Code	Telephone
Admit Date (mm/dd/yyyy)	Discharge / Transfer Date (mm/dd/yyyy)		
Medical Record Number	Discharge Diagnosis		

COMPLICATIONS AND OTHER SYMPTOMS

Pneumonia ☐ Yes ☐ No ☐Unknown	Encephalitis ☐ Yes ☐ No ☐Unknown	Otitis ☐ Yes ☐ No ☐Unknown	Diarrhea ☐ Yes ☐ No ☐Unknown	Thrombocytopenia ☐ Yes ☐ No ☐Unknown
Other Complications	If yes, describe:			
Did patient die? ☐ Yes ☐ No ☐Unknown	Date of Death (mm/dd/yyyy)			

VACCINATION HISTORY

Has the patient previously received measles vaccine?

☐ Yes ☐ No ☐ Unknown

Dose #1: If Yes, specify type of vaccine administered	Date of vaccination (if known) (mm/dd/yyyy)
Dose #2: If Yes, specify type of vaccine administered	Date of vaccination (if known) (mm/dd/yyyy)
Dose #3: If Yes, specify type of vaccine administered	Date of vaccination (if known) (mm/dd/yyyy)

Reason Not Vaccinated

☐ Personal Beliefs Exemption (PBE) ☐ Permanent Medical Exemption (PME) ☐ Temporary Medical Exemption ☐ Lab confirmation of previous disease
☐ MD diagnosis of previous disease ☐ Under age for vaccination ☐ Delay in starting series or between doses ☐ Unknown ☐ Other

If Other, specify:

MEDICAL HISTORY

Immunocompromised	Prior MD diagnosis of this disease?
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Other pre-existing conditions:

LABORATORY RESULTS
Case Lab Confirmed ☐ Yes ☐ No ☐Unknown
IF SEROLOGY OR OTHER LAB TESTS DONE, ADD THE LAB TESTS IN THE FOLLOWING SECTION (LABORATORY RESULTS — DETAILS

LABORATORY RESULTS – DETAILS – VIRUS ISOLATION			
Specimen obtained for virus isolation ☐ Yes ☐ No ☐Unknown	Date Specimen Collected (mm/dd/yyyy)	Specimen Source	If Other, specify:
Laboratory Name	Telephone		
Virus Isolated ☐ Yes ☐ No ☐Unknown			

LABORATORY RESULTS – DETAILS - BLOOD IgM	
Blood IgM ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown	Date Specimen Collected (mm/dd/yyyy)
Laboratory Name	Telephone

LABORATORY RESULTS – DETAILS - BLOOD IgG - Acute	
Blood IgG – Acute ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown	Date Specimen Collected (mm/dd/yyyy)
Laboratory Name	Telephone

LABORATORY RESULTS – DETAILS - BLOOD IgG - Convalescent	
Blood IgG – Convalescent ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown	Date Specimen Collected (mm/dd/yyyy)
Laboratory Name	Telephone

LABORATORY RESULTS – DETAILS - RESPIRATORY PCR	
Respiratory PCR ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown ☐ Unsatisfactory	Date Specimen Collected (mm/dd/yyyy)
Laboratory Name	Telephone

LABORATORY RESULTS – DETAILS - URINE PCR	
Urine PCR ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not Done ☐ Unknown ☐ Unsatisfactory	Date Specimen Collected (mm/dd/yyyy)
Laboratory Name	Telephone

LABORATORY RESULTS – DETAILS - GENOTYPE		
Genotype	Date Specimen Collected(mm/dd/yyyy)	
Laboratory Name	Telephone	

LABORATORY RESULTS – DETAILS - OTHER		
Other Test	Date Specimen Collected (mm/dd/yyyy)	Result
Laboratory Name	Telephone	

INCUBATION PERIOD

INCUBATION PERIOD IS 21 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

Did patient travel during the incubation period? ☐ Yes ☐ No ☐ Unknown	Did the patient have contact with travelers or visitors during the incubation period? ☐ Yes ☐ No ☐ Unknown
Travel Type ☐ Domestic ☐ International	
State	Country
Location Details	
Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
Did patient fly while infectious? ☐ Yes ☐ No ☐ Unknown	
Airline	Flight Number
Departure Date (mm/dd/yyyy)	Arrival Date (mm/dd/yyyy)

EPIDEMIOLOGICAL EXPOSURE HISTORY

Close contact with person(s) with rash during incubation period? ☐ Yes ☐ No ☐ Unknown	Exposure Setting

SPREAD SETTING

Setting Type	Name of Setting
First Date of Contact (mm/dd/yyyy)	Last Date of Contact (mm/dd/yyyy)
Number Exposed	Notes

GENERAL CONTACTS

Number of susceptible contacts
Close contacts with rash 8-17 days after exposure to case? ☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGICAL LINKAGE

Was this case part of a known case? ☐ Yes ☐ No ☐ Unknown
Part of known outbreak? ☐ Yes ☐ No ☐ Unknown

CASE DEFINITION (2013) - MEASLES

CLINICAL CASE DEFINITION

An illness characterized by all the following: (1) a generalized rash lasting greater than or equal to 3 days, (2) a temperature greater than or equal to 101.0oF (greater than or equal to 38.3oC), and (3) cough, coryza, or conjunctivitis

LABORATORY CRITERIA FOR DIAGNOSIS

Positive serologic test for measles immunoglobulin M antibody; significant rise in measles antibody level by any standard serologic assay; or isolation of measles virus from a clinical specimen

CASE CLASSIFICATION

Suspected: any febrile illness accompanied by rash

Probable: a case that meets the clinical case definition, has noncontributory or no serologic or virologic testing, and is not epidemiologically linked to a confirmed case

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed case (a laboratory confirmed case does not need to meet the clinical case definition)

Investigator Name (print)	Telephone Number
Agency Name	
Date (mm/dd/yyyy)	

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	