

CASE REPORT FORM

Measles, Mumps, Rubella

Measles Mumps Rubella		EpiSurv No. EpiSurvNumber	
Disease Name DiseaseName			
<input type="radio"/> Measles		<input type="radio"/> Mumps	
<input type="radio"/> Rubella			
Reporting Authority			
Name of Public Health Officer responsible for case OfficerName			
Notifier Identification			
Reporting source* ReportSrc		ReportDate	
<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 ReportName		Organisation ReportOrganisation	
Date reported* ReportDate		Contact phone ReportPhone	
Usual GP UsualGP		Practice GPPracticeName	
GP/Practice address		GP phone GPPhone	
Number houzenumber Street streetname Suburb suburb		Post Code postco... <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Town/City towncity			
Case Identification			
Name of case* Surname Surname		Given Name(s) GivenName	
NHI number* NHINumber		Email Email	
Current address* Number houzenum... Street streetname Suburb suburb		Post Code postcode <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Town/City towncity			
Phone (home) PhoneHome		Phone (work) PhoneWork	
		Phone (other) PhoneOther	
Case Demography			
Location TA* TA		DHB* DHB	
Date of birth* DateOfBirth		OR Age Age <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years AgeUnits	
Sex* Sex		<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown	
Occupation* Occupation			
Occupation location occupation_place_type		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name occupation_place_name			
Address Number houzenumb... Street streetname Suburb suburb		Post Code postcode <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Town/City towncity			
Alternative location occupation_place_type		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name occupation_place_name			
Address Number houzenumber Street streetname Suburb suburb		Post Code postcode <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Town/City towncity			
Ethnic group case belongs to* (tick all that apply)			
<input type="checkbox"/> NZ European EthNZEuroean		<input type="checkbox"/> Maori EthMaori	
<input type="checkbox"/> Niuean EthNiuean		<input type="checkbox"/> Chinese EthChinese	
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan) *(specify) EthOther EthSpecify1 _____ EthSpecify2 _____		<input type="checkbox"/> Samoan EthSamoan	
		<input type="checkbox"/> Cook Island Maori EthCookIslandMaori	
		<input type="checkbox"/> Tongan EthTongan	

Measles Mumps Rubella		EpiSurv No. <u>EpiSurvNumber</u>
Basis of Diagnosis		
CLINICAL CRITERIA		
Fits Clinical Description* FitClinDes		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Measles	Fever ≥ 38.0 ° C MeaslesFever	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Maculopapular Rash MeaslesRash	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	If yes, date of onset of rash* _____ MeaslesRashDate	
	Cough Coughing	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Coryza Coryza	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Conjunctivitis Measles Conjunctivitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Koplik's spots KoplikSpots	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Mumps	Acute swelling of parotid or other salivary gland for 2 or more days AcuteSwell	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Rubella	Fever ≥ 38.0 ° C RubellaFever	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Maculopapular Rash RubellaRash	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	If yes, date of onset of rash* _____ RubellaRashDate	
	Arthritis/arthritis Arthritis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Lymphadenopathy Lymphad	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
	Conjunctivitis RubellaConjunctivitis	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
LABORATORY CRITERIA		
Laboratory confirmation of disease* LabConf		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Awaiting Results
Confirmation Method		
<input type="checkbox"/> Isolation of virus from clinical specimen ConfIsolation	<input type="checkbox"/> Positive IgM antibody ConfIgM	<input type="checkbox"/> Significant rise in IgG antibody level ConfIgG
<input type="checkbox"/> Nucleic acid testing (NAT) ConfNAT	<input type="checkbox"/> Genetic characterisation ConfGenC	<input type="checkbox"/> ConfGenCSpec
EPIDEMIOLOGICAL CRITERIA		
Contact with a laboratory confirmed case* ConfCase		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
STATUS* Status	<input type="radio"/> Under investigation <input type="radio"/> Probable <input type="radio"/> Confirmed <input type="radio"/> Not a case	
Clinical Course and Outcome		
Date of onset* OnsetDt _____	<input type="checkbox"/> Approximate OnsetDtApprox	<input type="checkbox"/> Unknown OnsetDtUnknown
Hospitalised* Hosp	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date hospitalised* HospDt _____	<input type="checkbox"/> Unknown HospDtUnknown	
Hospital* HospName _____		
Died* Died	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
Date died* DiedDt _____	<input type="checkbox"/> Unknown DiedDtUnknown	
Was this disease the primary cause of death?* DiedPrimary		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If no, specify the primary cause of death* DiedOther		

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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)?*	
<input type="checkbox"/> Yes Outbrk If yes, specify Outbreak No.* OutbrkNo _____	
Risk Factors	
Contact with another case of the disease in previous 3 weeks* ContPrev	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Attendance at school, pre-school or childcare* AttenSch	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Was the case overseas during the incubation period (measles = 7 - 18 days; mumps = 12 - 25 days; rubella = 14 - 23 days) for this disease?* Overseas	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Other risk factors for measles, mumps or rubella (specify)* OtherRisk _____	
Protective Factors	
At any time prior to onset, had the case been immunised with the MMR or appropriate monovalent vaccine?* Immunised	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
If yes specify, vaccine details*	
First administered dose:* FirstDose	<input type="radio"/> MMR/Monovalent <input type="radio"/> Unknown
Date given* _____ DtFirstDose	Or age when first dose was given _____ <input type="radio"/> Wks <input type="radio"/> Mths <input type="radio"/> Yrs VMWFirstDose AgeFirstDose
Source of information* SceFirstDose	<input type="radio"/> Patient/caregiver recall <input type="radio"/> Documented
Second administered dose:* SecndDose	<input type="radio"/> MMR/Monovalent <input type="radio"/> Unknown
Date given* _____ DtSecndDose	Or age when second dose was given _____ <input type="radio"/> Wks <input type="radio"/> Mths <input type="radio"/> Yrs VMWSecndDose AgeSecndDose
Source of information* SceSecndDose	<input type="radio"/> Patient/caregiver recall <input type="radio"/> Documented
Management	
CASE MANAGEMENT	
Case excluded from work or school/pre-school/childcare for appropriate period Excluded	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA <input type="radio"/> Unknown
Was case pregnant (rubella only)?* Pregnant	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
If yes gestation period* Gestation _____ (weeks) at time of onset	
CONTACT MANAGEMENT	
Did the case have any contacts (measles only) CaseCont	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	
if yes, specify number and management	
Age of contacts	Number identified
< 15 months	_____ NoLT15 _____ NoLT15Susc _____ NoLT15MMR _____ NoLT15IG _____ NoLT15Declined
15 months and over	_____ NoGE15 _____ NoGE15Susc _____ NoGE15MMR _____ NoGE15IG _____ NoGE15Declined
Unimmunised susceptibles excluded from school/pre-school/childcare for appropriate period Unimmun	
<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> NA <input type="radio"/> Unknown	
Comments*	
Comments	