

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

MEASLES
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 22

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name First Middle Suffix Maiden/Other Alias Birthdate (mm/dd/yyyy) SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Was testing for rubella or measles done? Please specify disease
Date IgM specimen taken IgM result
Date IgG acute specimen taken IgG result
Date IgG convalescent specimen taken Specify other lab method Other results

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease?
CHECK ALL THAT APPLY:
Fever
Skin rash
Anatomic site rash began
Observed by health care provider
Duration of rash
Location
Appearance of rash
Skin itching (pruritis)
Cough
Onset date
Conjunctivitis
Runny nose and/or teary eyes (coryza)
Koplik's spots
Thrombocytopenia
Encephalitis
Otitis
Pneumonia
Diarrhea
Other symptoms, signs, clinical findings, or complications consistent with this illness?
MATERNAL INFORMATION
Was the mother of this infant/child case diagnosed with this disease?
Time frame of diagnosis
If date of birth is unknown, provide biologic mother's age in years:
Was the child breastfed?
Was the biologic mother born outside the US?
Date of biologic mother's arrival in the US
Did the biologic mother ever have evidence of serological IgG immunity?
Test date
Result
Was the child's biologic mother immunized with vaccine against this specific disease?
Type of vaccine information
Source of vaccine information

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

**NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE**

**Was patient hospitalized for this illness >24 hours?**  Y  N  U  
 Hospital name: \_\_\_\_\_  
 City, State: \_\_\_\_\_  
 Hospital contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Admit date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Discharge date (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Did patient have a travel history during the 4 days prior to onset of symptoms until 5 days after rash onset?**  Y  N  U

Travel dates: From: \_\_\_\_\_ until \_\_\_\_\_  
 To city: \_\_\_\_\_ State: \_\_\_\_\_  
 To country: \_\_\_\_\_

Reason(s) for travel:  
 Vacation / tourism  Airline / Ship crew  
 Organized tour  Missionary or dependent  
 Business related, specify \_\_\_\_\_  
 Military related  Refugee / Immigrant  
 Visit to family / friends  Student / Teacher  
 Peace corps  Unknown  
 Other \_\_\_\_\_

Mode(s) of transportation (check all that apply)  
 Airplane  
 Ship / boat / ferry  
     Cruise ship?  Y  N  U  
     Specify cruise line \_\_\_\_\_  
 Train / subway  
 On foot  
 Bus/taxi/shuttle  
 Automobile / motorcycle  
 Other, specify: \_\_\_\_\_

**Does the patient know anyone else with similar symptoms?**  Y  N  U  
 If yes, list person(s) and contact numbers: \_\_\_\_\_

**VACCINE**

**Has patient/contact ever received measles-containing vaccine?**  Y  N  U

**If yes, number of doses received on or after first birthday:** \_\_\_\_\_

**If yes, date of vaccination #1** (mm/dd/yyyy) \_\_\_\_\_  
 Vaccine type: \_\_\_\_\_  
 Manufacturer: \_\_\_\_\_  
 Product/trade name: \_\_\_\_\_  
 Lot number: \_\_\_\_\_

**If yes, date of vaccination #2**(mm/dd/yyyy) \_\_\_\_\_  
 Vaccine type: \_\_\_\_\_  
 Manufacturer: \_\_\_\_\_  
 Product/trade name: \_\_\_\_\_  
 Lot number: \_\_\_\_\_

Vaccine date unknown  Y  N

**If no, reason for inadequate vaccination:**  
 Religious exemption  
 Medical exemption  
 Medical contraindication  
 Philosophical exemption (outside NC only)  
 Laboratory evidence of previous disease  
 Physician diagnosis of previous disease  
 Under age for vaccination  
 Parental refusal  
 Missed opportunities  
 Unknown  
 Other, specify: \_\_\_\_\_

**Source of vaccine information:**  
 Patient's or Parent's verbal report  
 Physician\*  
 Medical record\*  
 Certificate of immunization record\*  
 Patient vaccine record\*  
 School record  
 Other, specify: \_\_\_\_\_  
 NCIR record  
 Unknown

**CLINICAL OUTCOMES**

**Discharge/Final diagnosis:** \_\_\_\_\_

**Duration of acute illness:** \_\_\_\_\_

Died from this illness?  Y  N  U  
 Patient died in North Carolina?  Y  N  U  
     County of death: \_\_\_\_\_  
 Died outside NC?  Y  N  U  
     Specify where: \_\_\_\_\_  
 Autopsy performed?  Y  N  U  
     Facility where autopsy was performed: \_\_\_\_\_

Patient autopsied in NC?  Y  N  U  
 County of autopsy: \_\_\_\_\_  
 Autopsied outside NC, specify where: \_\_\_\_\_  
 Source of death information (select all that apply):  
*Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.*  
 Death certificate  
 Autopsy report final conclusions  
 Hospital/physician discharge summary  
 Other: \_\_\_\_\_

Cause of death: \_\_\_\_\_  
 Death date (mm/dd/yyyy): \_\_\_\_\_

**PREDISPOSING CONDITIONS**

**Any immunosuppressive conditions?**  Y  N  U  
 Specify \_\_\_\_\_

**Other underlying illness**  Y  N  U  
 Please specify: \_\_\_\_\_

**Was the patient receiving any of the following treatments or taking any medications?**

Antibiotics  Y  N  U  
 For what medical condition? \_\_\_\_\_

Chemotherapy  Y  N  U  
 If yes, was therapy within the last 30 days before this illness?  Y  N  U  
 For what medical condition? \_\_\_\_\_

Radiotherapy  Y  N  U  
 If yes, was therapy within the last 30 days before this illness?  Y  N  U  
 For what medical condition? \_\_\_\_\_

**H2 blockers, proton pump, or ulcer medication** (e.g. Tagamet, Zantac, Omeprazole)  Y  N  U  
 If yes, was medication/therapy within the last 30 days before this illness?  Y  N  U  
 For what medical condition? \_\_\_\_\_

Systemic steroids/corticosteroids, including steroids taken by mouth or injection  Y  N  U  
 If yes, was medication taken within the last 30 days before this illness?  Y  N  U  
 For what medical condition? \_\_\_\_\_

Immunosuppressive therapy, including anti-rejection therapy  Y  N  U  
 If yes, specify: \_\_\_\_\_  
 If yes, was medication taken within the last 30 days before this illness?  Y  N  U  
 For what medical condition? \_\_\_\_\_

Aspirin or aspirin-containing product  Y  N  U  
 If yes, was medication taken within the last 30 days before this illness?  Y  N  U  
 For what medical condition? \_\_\_\_\_

**REASON FOR TESTING**

**Why was the patient tested for this condition?**  
 Symptomatic of disease  
 Screening of asymptomatic person with reported risk factor(s)  
 Exposed to organism causing this disease (asymptomatic)  
 Household / close contact to a person reported with this disease  
 Other, specify \_\_\_\_\_  
 Unknown

**TREATMENT**

**Did patient take an antibiotic as treatment for this illness?**  Y  N  U  
 If yes, specify antibiotic name: \_\_\_\_\_  
 Dose \_\_\_\_\_  
 Date antibiotic began (mm/dd/yyyy): \_\_\_\_\_  
 Date antibiotic ended (mm/dd/yyyy): \_\_\_\_\_  
 Number of days taken: \_\_\_\_\_  Unknown

**Has the patient ever received immune globulin?**  Y  N  U  
 When was the last dose received? (mm/dd/yyyy): \_\_\_\_\_

**PREGNANCY**

**Is the patient currently pregnant?**  Y  N  U  
 Estimated delivery date (mm/dd/yyyy): \_\_\_\_\_  
 Give number of weeks gestation at onset of illness: \_\_\_\_\_

**Did patient have prenatal care?**  Y  N  U  
 Setting of prenatal care  
 Public sector  
 Private sector  
 Unknown  
 Prenatal provider name: \_\_\_\_\_

**Did patient attend family planning clinic prior to conception?**  Y  N  U

**Has the patient ever been pregnant?**  Y  N  U  
 Total number of previous pregnancies by the biologic mother: \_\_\_\_\_

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

**ISOLATION/QUARANTINE/CONTROL MEASURES**

**Restrictions to movement or freedom of action?** .....  Y  N

Check all that apply:

Work       Sexual behavior

Child care       Blood and body fluid

School       Other, specify \_\_\_\_\_

Date control measures issued: \_\_\_\_\_

Date control measures ended: \_\_\_\_\_

Was patient compliant with control measures? .....  Y  N

**Local health director or designee implement additional control measures?** (example: cohort classrooms, special cleaning, active surveillance, etc.).....  Y  N

If yes, specify: \_\_\_\_\_

**Were written isolation orders issued?..**  Y  N

If yes, where was the patient isolated? \_\_\_\_\_

Date isolation started? \_\_\_\_\_

Date isolation ended? \_\_\_\_\_

Was the patient compliant with isolation? .....  Y  N

**Were written quarantine orders issued?** .....  Y  N

If yes, where was the patient quarantined? \_\_\_\_\_

Date quarantine started? \_\_\_\_\_

Date quarantine ended? \_\_\_\_\_

Was the patient compliant with quarantine?.....  Y  N

Notes: \_\_\_\_\_

**TRAVEL/IMMIGRATION**

**The patient is:**

Resident North Carolina

Resident of another state or US territory

Foreign visitor

Refugee

Refugee camp(s)? .....  Y  N  U

Name of camp \_\_\_\_\_

Location of camp \_\_\_\_\_

Country of birth \_\_\_\_\_

Last country prior to arrival in US \_\_\_\_\_

Date of entry to US \_\_\_\_\_

Recent immigrant

Country of birth \_\_\_\_\_

Last country prior to arrival in US \_\_\_\_\_

Date of entry to US \_\_\_\_\_

Foreign adoptee

Country of birth \_\_\_\_\_

Last country prior to arrival in US \_\_\_\_\_

Date of entry to US \_\_\_\_\_

None of the above

**Was patient pregnant while traveling?** .....  Y  N  U

**Does patient know anyone else with similar symptom(s) who had the same or similar travel history?** .....  Y  N  U

Name: \_\_\_\_\_

**Did patient have contact with a person with travel history during the period of interest?** .....  Y  N  U

Contact's name: \_\_\_\_\_

Travel dates: From: \_\_\_\_\_ until \_\_\_\_\_

To city: \_\_\_\_\_

To state: \_\_\_\_\_

To country: \_\_\_\_\_

**Is contact a:**

Resident of another state or US territory

Foreign visitor

Recent immigrant

Refugee

Foreign adoptee

Unknown

Other, specify: \_\_\_\_\_

**Notes:** \_\_\_\_\_

**CHILD CARE/SCHOOL/COLLEGE**

**Patient in child care?** .....  Y  N  U

Name of care provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Patient a child care worker or volunteer in child care?** .....  Y  N  U

Name of child care provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Patient a parent or primary caregiver of a child in child care?** .....  Y  N  U

Name of child care provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Is patient a student?** .....  Y  N  U

Type of school:

NC Public School (preK-12)

NC Private School (preK-12)

Other School (preK-12)

Community College/College/University

Other academic institution (i.e. trade school, professional school, etc)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Specify grade: \_\_\_\_\_

**Is patient a school WORKER / VOLUNTEER in NC school setting?** .....  Y  N  U

Type of school

NC Public School (preK-12)

NC Private School (preK-12)

Other School (preK-12)

Community College/College/University

Other academic institution (i.e. trade school, professional school, etc)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Notes:** \_\_\_\_\_

**BEHAVIORAL RISK & CONGREGATE LIVING**

**During the 4 days prior to onset of symptoms until 5 days after rash onset did the patient live in any congregate living facilities** (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? .....  Y  N  U

Name of facility: \_\_\_\_\_

Dates of contact: \_\_\_\_\_

**During the 4 days prior to onset of symptoms until 5 days after rash onset, did the patient attend social gatherings or crowded settings? ..**  Y  N  U

If yes, specify: \_\_\_\_\_

**In what setting was the patient most likely exposed?**

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

**Does the patient have any other risk factors for this disease?**.....  Y  N  U

Specify: \_\_\_\_\_

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

**HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS**

During the 4 days prior to onset of symptoms until 5 days after rash onset, did the patient have any of the following health care exposures?

Emergency Dept. (not hospitalized).....  Y  N  U

Visit/admit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown

Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Hospital .....  Y  N  U

Visit/admit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Has patient been discharged? .....  Y  N  U

Discharge date (mm/dd/yyyy): \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

LTC facility—resident .....  Y  N  U

Visit/admit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Has patient been discharged? .....  Y  N  U

Discharge date (mm/dd/yyyy): \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Outpatient facility—patient .....  Y  N  U

Visit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Visitor to health care setting .....  Y  N  U

Visit date (mm/dd/yyyy): \_\_\_\_\_

Until date (mm/dd/yyyy): \_\_\_\_\_

Frequency:

Once

Multiple times within this time period

Daily

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Worked or volunteered in health care or clinical setting .....  Y  N  U

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Occupation:

Physician

Physician's assistant or nurse practitioner

Nurse

Laboratory

Other

Unknown

Specify work setting or volunteer duties:

Was facility notified regarding ill patient?

Yes  No  Unknown  N/A

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Other, specify \_\_\_\_\_

Was patient employed in a laboratory? .....  Y  N  U

If yes, specify and give details: \_\_\_\_\_

**CASE INTERVIEWS/INVESTIGATIONS**

Was the patient interviewed? .....  Y  N  U

Date of interview (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Were interviews conducted with others? .....  Y  N  U

Who was interviewed?

Were health care providers consulted? .....  Y  N  U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? .....  Y  N  U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

**GEOGRAPHICAL SITE OF EXPOSURE**

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC

City \_\_\_\_\_

County \_\_\_\_\_

Outside NC, but within US

City \_\_\_\_\_

State \_\_\_\_\_

County \_\_\_\_\_

Outside US

City \_\_\_\_\_

Country \_\_\_\_\_

Unknown

Is the patient part of an outbreak of this disease? .....  Y  N

Notes:

## **Measles (Rubeola)**

### **2009 CDC Case Definition**

#### **Clinical case definition**

An illness characterized by all the following:

- a generalized rash lasting greater than or equal to 3 days
- a temperature greater than or equal to 101.0°F (greater than or equal to 38.3°C)
- cough, coryza, or conjunctivitis

#### **Laboratory criteria for diagnosis**

- Isolation of measles virus from a clinical specimen, or
- Detection of measles-virus-specific nucleic acid by polymerase chain reaction, or
- Significant rise in serum measles immunoglobulin G antibody level between acute- and convalescent-phase specimens, by any standard serologic assay, or
- Positive serologic test for measles immunoglobulin M antibody

#### **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.