

CASE REPORT FORM

Measles, Mumps, Rubella

		EpiSurv No.
Disease Name		
☐ Measles ☐ Mumps ☐ Rubella (i)		
Reporting Authority		
Name of Public Health Officer responsible for case 		
Notifier Identification (i)		
Reporting source* ☐ General Practitioner ☐ Hospital-based Practitioner ☐ Laboratory ☐ Self-notification ☐ Outbreak Investigation ☐ Other		
Name of reporting source 		Organisation
Date reported* dd/mm/yyyy	Laboratory sample date dd/mm/yyyy	Contact phone
Usual GP 	Practice 	GP phone
GP/Practice address Number Street Suburb Town/City Post Code ☐ GeoCode 		
Case Identification (i)		
Name of case* Surname Given Name(s) 		
NHI number* 	Email 	
Current address* Number Street Suburb Town/City Post Code ☐ GeoCode 		
Phone (home) 	Phone (work) 	Phone (other)
Case Demography		
Location	TA* 	DHB*
Date of birth* dd/mm/yyyy	OR Age ☐ Days ☐ Months ☐ Years	
Sex* ☐ Male ☐ Female ☐ Indeterminate ☐ Unknown		
Occupation* (i)		
Occupation location ☐ Place of Work ☐ School ☐ Pre-school		
Name 		
Address Number Street Suburb Town/City Post Code ☐ GeoCode 		
Alternative location ☐ Place of Work ☐ School ☐ Pre-school		
Name 		
Address Number Street Suburb Town/City Post Code ☐ GeoCode 		
Ethnic group case belongs to* (tick all that apply) (i) ☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori ☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan ☐ Other (such as Dutch, Japanese, Tokelauan) *(specify) 		

Basis of Diagnosis**CLINICAL CRITERIA** **Fits Clinical Description***☐ Yes ☐ No ☐ Unknown**Measles**Fever ≥ 38.0 °C present at time of rash onset☐ Yes ☐ No ☐ Unknown

Maculopapular rash

☐ Yes ☐ No ☐ Unknown

If yes, date of onset of rash*

 

Cough

☐ Yes ☐ No ☐ Unknown

Coryza

☐ Yes ☐ No ☐ Unknown

Conjunctivitis

☐ Yes ☐ No ☐ Unknown

Koplik's spots

☐ Yes ☐ No ☐ Unknown**Mumps**

Acute swelling of parotid or other salivary gland for more than 2 days

☐ Yes ☐ No ☐ Unknown

Orchitis

☐ Yes ☐ No ☐ Unknown**Rubella**

Fever

☐ Yes ☐ No ☐ Unknown

Maculopapular rash

☐ Yes ☐ No ☐ Unknown

If yes, date of onset of rash*

 

Arthritis/arthralgia

☐ Yes ☐ No ☐ Unknown

Lymphadenopathy

☐ Yes ☐ No ☐ Unknown

Conjunctivitis

☐ Yes ☐ No ☐ Unknown**LABORATORY CRITERIA****Laboratory confirmation of disease***☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results 

If yes, date of laboratory confirmation

 **Confirmation method**☐ Nucleic acid testing (NAAT/PCR)☐ Genetic characterisation (specify strain)☐ Significant rise in IgG antibody level☐ Positive IgM antibody**EPIDEMIOLOGICAL CRITERIA****Contact with a confirmed case***☐ Yes ☐ No ☐ Unknown

If yes, specify the EpiSurv number of the confirmed case*

CLASSIFICATION*☐ Under investigation ☐ Probable ☐ Confirmed ☐ Not a case **ADDITIONAL LABORATORY DETAILS****Genotype****Strain name****Strain ID****Updated**☐**Laboratory****Date result updated** **Sample number****Clinical Course and Outcome****Date of onset*** ☐ Approximate☐ Unknown**Hospitalised***☐ Yes☐ No☐ Unknown**Date hospitalised*** ☐ Unknown**Hospital***

	EpiSurv No.
Clinical Course and Outcome continued	
Died* ☐ Yes ☐ No ☐ Unknown	
Date died* dd/mm/yyyy ☐ Unknown	
Was this disease the primary cause of death?* ☐ Yes ☐ No ☐ Unknown	
If no, specify the primary cause of death* 	
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)?* ☐ Yes If yes, specify Outbreak No.*	
Risk Factors	
Contact with another case of the disease during the incubation period for this disease* ☐ Yes ☐ No ☐ Unknown	
Was the case overseas during the incubation period for this disease?* ☐ Yes ☐ No ☐ Unknown	
If yes, date arrived in New Zealand* dd/mm/yyyy	
Specify countries visited* (from most recent to least recent)	
Country/Region*	Date Entered*
Last*	dd/mm/yyyy
Second Last*	dd/mm/yyyy
Third Last*	dd/mm/yyyy
Other risk factors for measles, mumps or rubella (specify)*	
Source (measles and rubella only)	
What was the source of the virus?* ☐ Imported ☐ Import-related ☐ Endemic ☐ Unknown	
If imported, specify country* Specify region /city*	
If import-related, specify the EpiSurv number of the source case*	
If the case was infected in New Zealand, specify the DHB where contact occurred*	
Protective Factors	
At any time prior to onset, had the case been immunised with the MMR or appropriate monovalent vaccine at 12 months or older?* ☐ Yes ☐ No ☐ Unknown	
If yes specify, vaccine details*	
First administered dose:*	☐ MMR/Monovalent ☐ Unknown
Date given* dd/mm/yyyy	Or age when first dose was given ☐ Weeks ☐ Months ☐ Years
Source of information*	☐ Patient/caregiver recall ☐ Documented
Second administered dose:*	☐ MMR/Monovalent ☐ Not given ☐ Unknown
Date given* dd/mm/yyyy	Or age when second dose was given ☐ Weeks ☐ Months ☐ Years
Source of information*	☐ Patient/caregiver recall ☐ Documented
Was the case given an MMR0 (or appropriate monovalent vaccine) dose when they were aged under 12 months? * ☐ Yes ☐ No ☐ Unknown	
If yes, date given* dd/mm/yyyy	Or age when dose zero was given ☐ Weeks ☐ Months ☐ Years
Source of information*	☐ Patient/caregiver recall ☐ Documented

	EpiSurv No.
Management	
CASE MANAGEMENT	
Date case investigation was started* (measles and rubella only) dd/mm/yyyy	
Was case pregnant (rubella only)?* ☐ Yes ☐ No ☐ Unknown 	
If yes, gestation period* (weeks) at time of onset	
CONTACT MANAGEMENT	
Flight details if case infectious while on board an international flight (measles only)*	
	Last flight 2nd to last flight 3rd to last flight 4th to last flight
Flight number(s)	
Date of departure	dd/mm/yyyy dd/mm/yyyy dd/mm/yyyy dd/mm/yyyy
Comments*	