

CASE REPORT FORM

Measles, Mumps, Rubella

Measles Mumps Rubella		EpiSurv No.	
Disease Name			
☐ Measles		☐ Mumps	
		☐ Rubella 	
Reporting Authority			
Name of Public Health Officer responsible for case			
Notifier Identification 			
Reporting source* ☐ General Practitioner ☐ Hospital-based Practitioner ☐ Laboratory ☐ Self-notification ☐ Outbreak Investigation ☐ Other			
Name of reporting source		Organisation	
Date reported*	Laboratory sample date	Contact phone	
Usual GP	Practice	GP phone	
GP/Practice address Number Street Suburb Town/City Post Code ☐ GeoCode			
Case Identification 			
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*		OR Age	
		☐ Days ☐ Months ☐ Years	
Sex* ☐ Male ☐ Female ☐ Unknown ☐ Other			
Occupation* 			
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) 			
☐ NZ European ☐ Maori ☐ Samoan ☐ Cook Island Maori			
☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan			
☐ Other (such as Dutch, Japanese, Tokelauan) *(specify)			

Measles Mumps Rubella		EpiSurv No. 	
Basis of Diagnosis			
CLINICAL CRITERIA (i)			
Fits Clinical Description*		☐ Yes ☐ No ☐ Unknown	
Measles	Fever $\geq 38.0^{\circ}\text{C}$ 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 (i)	
	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 (i)			
ADDITIONAL LABORATORY DETAILS			
Genotype	 	Strain name	
		N450 Strain ID	
		MF-NCR 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*	 		

Measles Mumps Rubella	EpiSurv No.																		
Clinical Course and Outcome continued																			
Died* ☐ Yes ☐ No ☐ Unknown Date died* ☐ 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 i Was the case overseas during the incubation period for this disease?* ☐ Yes ☐ No ☐ Unknown If yes, date arrived in New Zealand* Specify countries visited* (from most recent to least recent) <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%; text-align: left; padding: 5px;">Country/Region*</th> <th style="width: 20%; text-align: left; padding: 5px;">Date Entered*</th> <th style="width: 40%; text-align: left; padding: 5px;">Date Departed*</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Last* </td> <td style="padding: 5px;"> </td> <td style="padding: 5px;"> </td> </tr> <tr> <td style="padding: 5px;">Second Last* </td> <td style="padding: 5px;"> </td> <td style="padding: 5px;"> </td> </tr> <tr> <td style="padding: 5px;">Third Last* </td> <td style="padding: 5px;"> </td> <td style="padding: 5px;"> </td> </tr> </tbody> </table> Other risk factors for measles, mumps or rubella (specify)*		Country/Region*	Date Entered*	Date Departed*	Last*			Second Last*			Third Last*								
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Last*																			
Second Last*																			
Third Last*																			
Source (measles and rubella only)																			
What was the source of the virus?* ☐ Imported ☐ Import-related ☐ Endemic ☐ Unknown i 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* <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;">First administered dose:*</td> <td style="width: 30%; padding: 5px;">☐ MMR/Monovalent ☐ Unknown</td> <td style="width: 40%; padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">Date given* </td> <td style="padding: 5px;">Or age when first dose was given </td> <td style="padding: 5px;">☐ Weeks ☐ Months ☐ Years</td> </tr> <tr> <td style="padding: 5px;">Source of information*</td> <td colspan="2" style="padding: 5px;">☐ Patient/caregiver recall ☐ Documented</td> </tr> <tr> <td style="padding: 5px;">Second administered dose:*</td> <td style="padding: 5px;">☐ MMR/Monovalent ☐ Not given ☐ Unknown</td> <td style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">Date given* </td> <td style="padding: 5px;">Or age when second dose was given </td> <td style="padding: 5px;">☐ Weeks ☐ Months ☐ Years</td> </tr> <tr> <td style="padding: 5px;">Source of information*</td> <td colspan="2" style="padding: 5px;">☐ Patient/caregiver recall ☐ Documented</td> </tr> </table> 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* Or age when dose zero was given ☐ Weeks ☐ Months ☐ Years Source of information* ☐ Patient/caregiver recall ☐ Documented		First administered dose:*	☐ MMR/Monovalent ☐ Unknown		Date given*	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*	Or age when second dose was given	☐ Weeks ☐ Months ☐ Years	Source of information*	☐ Patient/caregiver recall ☐ Documented	
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Measles Mumps Rubella

EpiSurv No.

Management

CASE MANAGEMENT

Date case investigation was started* (measles and rubella only)

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				

Comments*