

ACUTE FEVER AND RASH (AFR) / MEASLES AND RUBELLA CASE INVESTIGATION FORM

1. Reporting information:

Country: _____ EPID Number: _____
 Health facility name: _____ District: _____
 State: _____ Province: _____
 Name of investigator: _____ Contact number: _____
 Date of notification: _____ Source of notification _____ Date of investigation: _____
 (dd/mm/yyyy) (dd/mm/yyyy)

2. Case identification:

NAME OF PATIENT: _____ **SEX:** Male Female
First name Last name
DATE OF BIRTH: _____ **AGE:** _____ year(s), and _____ month(s)
(dd/mm/yyyy)
 Pregnant?: Yes No Unknown If yes, weeks of pregnancy at rash onset: _____
 Name of parent/guardian: _____
 Address of patient: **HOUSE NO.:** _____ **STREET:** _____ **VILLAGE:** _____
DISTRICT: _____ **PROVINCE:** _____ **STATE:** _____

3. Vaccination history

Type of vaccine received: MR MMR **Number of doses received:** 1 2 3 >3 Unknown
Date of last dose: _____ Source of information: Vaccination card Verbal
(dd/mm/yyyy)

4. Clinical signs and symptoms:

Acute fever: Yes No Unknown Date of fever onset: _____
(dd/mm/yyyy)
RASH: Yes No Unknown **DATE OF RASH ONSET:** _____
(dd/mm/yyyy)
 Cough: Yes No Unknown Runny nose: Yes No Unknown
 Red eyes: Yes No Unknown Koplik spot: Yes No Unknown
 Arthralgia/Arthritis: Yes No Unknown
 Enlarged lymph node: Yes No Unknown If yes, location: cervical suboccipital postauricular other

5. Complications

Otitis media: Yes No Unknown Pneumonia: Yes No Unknown
 Diarrhoea: Yes No Unknown Encephalitis: Yes No Unknown
 Miscarriage: Yes No Unknown Other (specify): _____

6. Hospitalization

Hospitalized?: Yes No Unknown If yes, name of hospital: _____
 Date of admission: _____ Date of discharge: _____
(dd/mm/yyyy) (dd/mm/yyyy)

7. Final outcome

Death: Yes No Unknown If yes, date of death: _____
(dd/mm/yyyy)

8. Recent travel and contact history

ANY TRAVEL WITHIN 7-23 DAYS BEFORE RASH ONSET?: Yes No Unknown

Dates of travel: _____ Destinations: _____

 (dd/mm/yyyy)

ANY CONTACT WITH A SIMILAR CASE 7-23 DAYS PRIOR TO RASH ONSET?: Yes No Unknown

Name	Relationship	Contact dates	Contact location

ANY SIMILAR CASE IN AREA 7-23 DAYS PRIOR TO RASH ONSET?: Yes No Unknown

Comment: _____

Any visit to a health facility 7-23 days before symptom onset apart from one due to current illness?:

Yes No Unknown

If yes, dates of visit/hospitalization and name of the facility: _____
 (dd/mm/yyyy) Health facility name

Suspected source of infection: Home Health care facility School Community Other Unknown

9. Sample collection

Sample collected?: Yes No Unknown Name of sample collector: _____

Sample type <i>(S=serum, D=DBS, T=throat swab, N=nasopharyngeal swab, O=other; if other, please specify)</i>	Date of collection <i>(dd/mm/yyyy)</i>	Date sent to lab <i>(dd/mm/yyyy)</i>	Laboratory no. <i>(Lab to complete)</i>

10. Laboratory results *(Lab to complete)*

Laboratory no.	Date received <i>(dd/mm/yyyy)</i>	Sample status <i>(good, bad)</i>	Date tested <i>(dd/mm/yyyy)</i>	Date result <i>(dd/mm/yyyy)</i>	Result			Genotype detected
					Measles IgM	Rubella IgM	PCR	

11. Final classification

MEASLES

- LABORATORY CONFIRMED MEASLES
 - IMPORTED FROM WHERE? _____
 - IMPORT-RELATED FROM WHERE? _____
 - ENDEMIC
 - UNKNOWN
- EPI-LINKED MEASLES
- CLINICALLY COMPATIBLE MEASLES
- DISCARDED AS NON-MEASLES

RUBELLA

- LABORATORY CONFIRMED RUBELLA
 - IMPORTED FROM WHERE? _____
 - IMPORT-RELATED FROM WHERE? _____
 - ENDEMIC
 - UNKNOWN
- EPI-LINKED RUBELLA
- CLINICALLY COMPATIBLE RUBELLA
- DISCARDED AS NON-RUBELLA