Contra Costa Public Health
(925) 313-6740
FAX: (925) 313-6465

Measles Case History Form

REQUIRED INFORMATION

IMPORTANT NOTE:

*ALL **suspect cases MUST** be **reported (24/7) by telephone** to Contra Costa Public Health (925) 313-6740 and before submitting any specimens for testing (see directions on pg.2)*

Patient Demographics:

Name:_____
DOB:_____
MRN:_____
Gender: □ Female □ Male □ NonBinary □ Unknown

AND ***Print copy*** of demographic sheet and fax with form

Healthcare Provider Information:

Provider Name:	**Facility Name:**
Address:	**Suite:**
City:	**Facility Type:** □ Providers Office □ Urgent Care □ Hospital
Telephone #:	**Fax #:**

Significant Medical History:

Symptom Onset: ___/____/_____ (MM/DD/YYYY)	**Rash Onset:** ____/____/_____ (MM/DD/YYYY) □ N/A	**Fever Onset:** ____/____/_____ (MM/DD/YYYY) Max Temp: _____

Symptoms that occurred prior and during evaluation:
□ Rash □ Fever □ Cough □ Coryza □ Conjunctivitis
□ Koplik Spots (white spots in mouth) □ Sore Throat
□ Other: _____

_____

Rash Details:

Appearance: _____

_____

Body origin: _____
Progression/Direction: _____

_____

Itchy rash? □ Yes □ No If yes, onset: _____
Any alternate explanations (i.e. allergic reaction, etc.)?
□ Yes □ No
If yes, details: _____

_____

Vaccination History:

Patient vaccinated for Measles? □Yes □No □Unknown
If yes, how many doses of MMR? □One □Two □Three
If known, dates of MMR vaccinations:

Dose 1: ____/____/_____ (MM/DD/YYYY)	**Dose 2:** ____/____/_____ (MM/DD/YYYY)	□ Recent measles vaccine in the last 6 to 45 days

If patient is <6 months old, was mom vaccinated?
□Yes □No □Unknown

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Epidemiologic Information (during 21 days before rash onset):

(1) Known exposure to a person with measles?
□ Yes □ No
If yes, details: _____
_____

(2) Contact with an international visitor? □ Yes □ No

(3) International travel - outside of the U.S., including Canada and Mexico? □ Yes □ No
If yes, details (locations & dates): _____
_____
_____

(4) Domestic travel – through an international airport or popular tourist attraction? □ Yes □ No
If yes, details (locations & dates): _____
_____
_____

(5) Resides in or visited a community with measles cases? □ Yes □ No
If yes, details (locations & dates): _____
_____
_____

Key Healthcare Dates:

Office Visit Date ____/____/_____ (MM/DD/YYYY)	**Urgent Care Date** ____/____/_____ (MM/DD/YYYY)
ER Date ____/____/_____ (MM/DD/YYYY)	**Admission Date** ____/____/_____ (MM/DD/YYYY)

Status:

□ **Sent home** and advised to self-isolate at home until test results are back
Transportation method:
□Private Car □Taxi □Bus □Unknown
□ **Hospitalized** and isolated in airborne precautions

Diagnostic/Laboratory Studies:

Specimen source(s) (check all that apply):
□ Throat swab (Dacron swab) in viral transport media
□ Urine (10-50 cc)
□ Nasopharyngeal swab in viral transport media
□ Blood (7-10 mLs) in red top or serum separator tube – ONLY patients VACCINATED in last 45 days

STEP 1:
REPORT SUSPECT CASE **(24/7) BY TELEPHONE** TO PUBLIC HEALTH AT **925-313-6740**
(or, after hours the Health Officer can be reached at 925-646-2441), **AND**
OBTAIN APPROVAL BY PUBLIC HEALTH **FOR LAB TESTING** AT THE PUBLIC HEALTH LABORATORY

STEP 2:
Complete as many fields as possible on this form

STEP 3:
FAX A COPY OF THIS **FORM** TO PUBLIC HEALTH AT **(925) 313-6465, AND**
SUBMIT SPECIMEN(S) WITH A **LAB REQUISITION FORM** (cchealth.org/laboratory)