

National Institute of Virology, Pune 411001

Measles Case Investigation Form

Name of Patient:

Address:

Date of birth:

Age:

Sex:

CLINICAL DATA

Symptoms and signs

Date of onset:

Fever: Yes/No.....days

Cough: Yes/No.....days

Cold (coryza): Yes/No.....days

Conjunctivitis: Yes/No.....days

Lymphadenopathy: Yes/No.....days

Rash: Yes/No.....days

Type of rash: macular/popular/maculopapular

Spread of rash:

Other Important Clinical Features:

Complications

None/Diarrhoea/Pneumonia/Otitis media/Encephalitis

Others (specify):

Measles Vaccination Status

Yes/No

MMR: one dose/ two doses

Date/s of Immunization:

Place of Immunization:

Name of Clinician/GP:

Vaccine details (batch, make etc):

Contact History (Within 3 weeks prior to onset of illness)

Family Contacts:

Neighborhood contacts:

Patient hospitalization

Hospitalization: Yes/No

Date:

Treatment given (if any):

Hospital name:

Hospital No:

Ward No:

Date of discharge/transfer/death:

Outcome of case: Cured/transferred/died/not known

CLINICAL SAMPLES TAKEN FOR LABORATORY INVESTIGATION

Blood/Serum/ Cerebrospinal fluid (CSF):

Throat /Oral swabs:

Urine:

Others (specify):

Name of Investigator:

Date:

Place: