

NSW HEALTH - MEASLES CASE QUESTIONNAIRE

SUMMARY

Date of notification:		Interviewer:	
Date of interview:		NCIMS ID:	Managing PHU:
Person interviewed if not case:		Relationship to case:	
*Case classification refer to case definition <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected			
Notification Details			
Notifier		Notifier type:	
Sent date:		Received date:	
		<input type="checkbox"/> Clinician	<input type="checkbox"/> Laboratory
		<input type="checkbox"/> Hospital	<input type="checkbox"/> Other, specify:

CASE DEMOGRAPHICS

First name:		Last name:	
Date of birth:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Another term (specify):	
*Does the case identify as being of Aboriginal and/or Torres Strait Islander origin?			
<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> Both Aboriginal and Torres Strait Islander	
<input type="checkbox"/> Non-Indigenous	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not stated	
Country of birth:		Interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify:	
Address:			
Suburb:		Postcode:	
Contact number:		Email:	

Vaccination History

*Vaccinated against measles? <input type="checkbox"/> Yes, detail below <input type="checkbox"/> No <input type="checkbox"/> Unknown		If not vaccinated, reason?
Dose 1 brand:	Date:	<input type="checkbox"/> Chose not to <input type="checkbox"/> Too young for first dose <input type="checkbox"/> History of infection <input type="checkbox"/> Other (please add notes)
Validation: <input type="checkbox"/> AIR <input type="checkbox"/> Dr/health record <input type="checkbox"/> Self-reported <input type="checkbox"/> Unable to validate		
Dose 2 brand:	Date:	
Validation: <input type="checkbox"/> AIR <input type="checkbox"/> Dr/health record <input type="checkbox"/> Self-reported <input type="checkbox"/> Unable to validate		

Vaccination notes:

CLINICAL INFORMATION

Symptoms			
*Did the case have symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of 1 st symptom onset:	
Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Onset:	

Coryza	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Onset:	
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Onset:	
Diarrhoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Onset:	
Koplik's spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Onset:	
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Onset:	Highest temp: °C
*Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Onset:	
Rash details:					
Is the case immunocompromised?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(if yes, add relevant detail below)
Is the case pregnant? (if relevant)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other symptoms or relevant clinical history:					

Treating Clinician	
Name of clinician:	Clinic name:
Phone number:	Address:
Event Outcome	
*Was the case hospitalised?	<input type="checkbox"/> No <input type="checkbox"/> Yes
MRN:	<input type="checkbox"/> Unknown
	date admitted:
	date discharged:
Hospital:	
*Outcome: <input type="checkbox"/> Alive <input type="checkbox"/> Died <input type="checkbox"/> Unknown	
If died, death related to measles? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of death:	

RISK HISTORY		
Period of Interest		
Incubation period (-18 days) Start date:	Infectious period start (-1 day) Date:	Infectious period end (+4 days) Date:

Incubation period			Infectious period								
-18 days from prodrome onset, or -14 days from rash onset if no clear prodrome			-1 day from prodrome onset OR -4 days from rash onset if no clear prodrome, until +4 days after rash onset								
-18 days	-10 days	-7 days	-1	prod.			rash				+4

Infectious in the community risk flag	<input type="checkbox"/> Red (high risk)	<input type="checkbox"/> Amber (moderate risk)	<input type="checkbox"/> Green (low/no risk)
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Occupation:	Employer/school/childcare:		
Last date attended:	High-risk occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
High-risk setting exposures			
In the period of interest, did the case spend time in any of the following settings:			
<input type="checkbox"/> Childcare/pre-school <input type="checkbox"/> GP / Doctor's clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Other <i>specify:</i>			
Setting / facility name:		Date of exposure:	
Setting / facility name:		Date of exposure:	
Travel Information			
Is the case a visitor or traveller to NSW?			
<input type="checkbox"/> International traveller <input type="checkbox"/> Inter-state traveller, <i>list state:</i> <input type="checkbox"/> No , NSW resident			
Did the case travel outside of NSW in the period of interest?			
<input type="checkbox"/> Yes, overseas <i>list countries:</i> <input type="checkbox"/> Yes, interstate <i>list state/s:</i> <input type="checkbox"/> Unknown <input type="checkbox"/> No (<i>move to page 3</i>)			
Dates of travel			
Departed NSW:		Returned to NSW:	
Flight information			
Airline/flight number:		Seat number:	
Departure date:		Arrival date:	
Departing airport:		Arrival airport:	
Reason for travel			
<input type="checkbox"/> Holiday/tourism <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Work/business <input type="checkbox"/> Education <input type="checkbox"/> Other <i>specify:</i>			
Travel / other exposure notes:			
*What was the case's most likely place of infection?			
<input type="checkbox"/> Locally acquired in NSW <input type="checkbox"/> Acquired interstate (<i>specify state/territory</i>): <input type="checkbox"/> Unknown <input type="checkbox"/> Acquired overseas (<i>specify country/s</i>):			
*Is there an epidemiological link?			
Outbreak ID if applicable:			
<input type="checkbox"/> No epidemiological link <input type="checkbox"/> Contact of a known case <i>NCIMS ID:</i>			
<input type="checkbox"/> Under investigation <input type="checkbox"/> Exposure at known location <i>venue:</i>			

Case Timeline – Exposures			
Symptom onset	Date	Time (HH:MM) Eg: 14:00 or 07:00	Details
+4 days			
+3 days			
+2 days			
+1 day			
Day 0			
-1 day			
-2 days			
-3 days			
-4 days			
-5 days			
-6 days			
-7 days			
-8 days			
-9 days			
-10 days			
-11 days			
-12 days			
-13 days			
-14 days			
-15 days			
-16 days			
-17 days			
-18 days			

*Refer to [Pages 6 & 7](#) for contact tracing line list

LABORATORY INVESTIGATIONS				
Test ordered	Specimen site/s	Collection date	Result	Lab
Serum IgG	Blood			
Serum IgM	Blood			
Urine PCR	Urine			
Nose/Throat PCR				
<i>Other</i>				
<i>Other</i>				

Other

Specimen referred to VIDRL for genotyping? Yes Unknown No, reason:

Testing notes:

NOTES

Large empty rectangular area for notes.

CONTACT TRACING

Name	Contact type <i>e.g. household, social</i>	DOB or age	Contact details	Date of 1st exposure	Symptomatic?	Vaccinated / immune?	Notes
					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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A contact tracing line list -excel template is available on the [ID Network SharePoint](#).