

**New Jersey Department of Health and Senior Services
Vaccine Preventable Diseases Program
PO Box 369
Trenton, NJ 08625-0369**

Case Status
<input type="checkbox"/> Confirmed
<input type="checkbox"/> Probable
<input type="checkbox"/> Suspect

MEASLES SURVEILLANCE WORKSHEET

Patient Name (Last, First)		Telephone No.	CDRSS #	E#
Street Address		City	Zip	County
Reporting Source	Treating Physician	Address of Physician		Telephone No.
Dates Physician Saw	Name of Investigator	Name of Agency		Telephone No.
Hospital	Hospital Record Number	Hospital Address		Telephone No.
Country of Birth	Birth Date ____/____/____ (mm/dd/yy)	Age _____ (Unknown = 999)	Age Type 0 <input type="checkbox"/> 0-120 Years 2 <input type="checkbox"/> 0-2 Weeks 1 <input type="checkbox"/> 0-11 Months 3 <input type="checkbox"/> 0-28 Days 9 <input type="checkbox"/> Age Unknown	
Ethnicity H <input type="checkbox"/> Hispanic N <input type="checkbox"/> Not Hispanic U <input type="checkbox"/> Unknown	Race N <input type="checkbox"/> Native American/Alaskan Native W <input type="checkbox"/> White A <input type="checkbox"/> Asian/Pacific Islander O <input type="checkbox"/> Other B <input type="checkbox"/> African American U <input type="checkbox"/> Unknown		Sex M <input type="checkbox"/> Male F <input type="checkbox"/> Female U <input type="checkbox"/> Unknown	
Event Date ____/____/____ (mm/dd/yy)	Event Type 1 <input type="checkbox"/> Onset Date 3 <input type="checkbox"/> Lab Test Date 5 <input type="checkbox"/> Reported to State or MMWR Report Date 2 <input type="checkbox"/> Diagnosis Type 4 <input type="checkbox"/> Reported to County 9 <input type="checkbox"/> Unknown			
Outbreak Associated _____ (Unknown = 999)	Reported ____/____/____ (mm/dd/yy)	Imported 1 <input type="checkbox"/> Indigenous 3 <input type="checkbox"/> Out of State 2 <input type="checkbox"/> International 9 <input type="checkbox"/> Unknown		Report Status 1 <input type="checkbox"/> Confirmed 3 <input type="checkbox"/> Not a Case 2 <input type="checkbox"/> Probable 9 <input type="checkbox"/> Unknown

CLINICAL DATA				COMPLICATIONS			
Symptoms	Yes	No	Unknown	Symptoms	Yes	No	Unknown
Any Rash If Yes, Date of Rash Onset: ____/____/____ (mm/dd/yy) Rash Duration: _____ (0-30; 99 = Unknown)				Otitis			
				Diarrhea			
				Pneumonia			
				Encephalitis			
				Thrombocytopenia			
Rash Generalized				Death			
Fever If Recorded, Highest Measured Temperature _____.____ Degrees F. (36.0 – 110.0; 999=Unknown)				Other Complications (If Yes, specify):			
Cough				Hospitalized? (If Yes, Days Hospitalized): _____ (0-998; 999 = Unknown)			
Coryze							
Conjunctivitis							

MEASLES SURVEILLANCE WORKSHEET, Continued

LABORATORY			
Was Laboratory Testing for Measles Done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date IgM Specimen Taken ____/____/____ (mm/dd/yy)	Result P <input type="checkbox"/> Positive X <input type="checkbox"/> Not Done E <input type="checkbox"/> Pending I <input type="checkbox"/> Indeterminate N <input type="checkbox"/> Negative U <input type="checkbox"/> Unknown	
Date IgG Acute Specimen Taken ____/____/____ (mm/dd/yy)	Date IgG Convalescent Specimen Taken ____/____/____ (mm/dd/yy)	Result P <input type="checkbox"/> Significant Rise in IgG X <input type="checkbox"/> Not Done N <input type="checkbox"/> No Significant Rise in IgG E <input type="checkbox"/> Pending I <input type="checkbox"/> Indeterminate U <input type="checkbox"/> Unknown	
Other Lab Result P <input type="checkbox"/> Positive I <input type="checkbox"/> Indeterminate E <input type="checkbox"/> Pending N <input type="checkbox"/> Negative X <input type="checkbox"/> Not Done U <input type="checkbox"/> Unknown		Specify Other Lab Method	
VACCINE HISTORY			
Vaccinated? (Received measles-containing vaccine?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of doses received ON or AFTER 1st birthday:	If not vaccinated, what was the reason? 1 <input type="checkbox"/> Religious Exemption 6 <input type="checkbox"/> Under Age for Vaccination 2 <input type="checkbox"/> Medical Contraindication 7 <input type="checkbox"/> Parental Refusal 3 <input type="checkbox"/> Philosophical Objection 8 <input type="checkbox"/> Other 4 <input type="checkbox"/> Lab Evidence of Previous Disease 9 <input type="checkbox"/> Unknown 5 <input type="checkbox"/> MD Diagnosis of Previous Disease	
Vaccination Date (MM/DD/YY)	Vaccine Type Code (A=MMR, B=Rubella, O=Other, U=Unknown)	Vaccine Manuf. Code (M=Merck, O=Other, U=Unknown)	Lot Number
EPIDEMIOLOGIC			
Date First Reported to a Health Dept. ____/____/____ (mm/dd/yy)	Date Case Investigation Started ____/____/____ (mm/dd/yy)	Outbreak Related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, Outbreak Name
Transmission Setting (Where did this case acquire measles?) 1 <input type="checkbox"/> Day Care 6 <input type="checkbox"/> Hospital Outpatient Clinic 11 <input type="checkbox"/> Military 2 <input type="checkbox"/> School 7 <input type="checkbox"/> Home 12 <input type="checkbox"/> Correctional Facility 3 <input type="checkbox"/> Doctor's Office 8 <input type="checkbox"/> Work 13 <input type="checkbox"/> Church 4 <input type="checkbox"/> Hospital Ward 9 <input type="checkbox"/> Unknown 14 <input type="checkbox"/> International Travel 5 <input type="checkbox"/> Hospital ER 10 <input type="checkbox"/> College 15 <input type="checkbox"/> Other			If Transmission Setting not among those listed and known, what was the transmission setting? Were Age and Setting Verified? (Is age appropriate for setting, i.e., aged 49 years and in day care, etc.?) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Source of Exposure for Current Case (Enter State ID if source was an in-state case; enter Country if source was out of US; enter State if source was out-of-state):		Epi-Linked to Another Confirmed or Probable Case? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No	Is Case Traceable within 2 Generations to an International Import? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No
CONTACT INFORMATION (FOR STATISTICAL USE)			
Mother's Name		Telephone Number	
Father's Name		Telephone Number	

MEASLES SURVEILLANCE WORKSHEET, Continued

ACTIVITY HISTORY FOR 18 DAYS BEFORE RASH ONSET AND 7 DAYS AFTER RASH ONSET	
Day -18	
Day -17	
Day -16	
Day -15	
Day -14	
Day -13	
Day -12	
Day -11	
Day -10	
Day -9	
Day -8	
Day -7	
Day -6	
Day -5	
Day -4	
Day -3	
Day -2	
Day -1	
Day 0 (Rash Onset)	
Day 1	
Day 2	
Day 3	
Day 4	
Day 5	
Day 6	
Day 7	

Clinical Case Definition:

A generalized rash lasting ≥ 3 days, a temperature $\geq 101.0^\circ \text{F}$ ($\geq 38.3^\circ \text{C}$), and cough, coryza, or conjunctivitis.

Case Classification:

Suspected: any febrile illness accompanied by rash.

Probable: a case that meets the clinical case definition, has non-contributory or no serologic or virologic testing, and is not epidemiologically linked to a laboratory-confirmed case.

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed case. A laboratory-confirmed case does not need to meet the clinical case definition.