North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

MEASLES
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 22

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Was testing for rubella or measles done? ☐ Yes ☐ No ☐ Unknown

Please specify disease ☐ Measles ☐ Rubella

Date IgM specimen taken Month Day Year

IgM result ☐ Positive ☐ Indeterminate ☐ Not done ☐ Negative ☐ Pending ☐ Unknown

Date IgG acute specimen taken Month Day Year

IgG result ☐ Signficant rise in IgG ☐ Indeterminate ☐ Not done ☐ No significant rise in IgG ☐ Pending ☐ Unknown

Date IgG convalescent specimen taken Month Day Year

Specify other lab method

Other results ☐ Positive ☐ Indeterminate ☐ Not done ☐ Negative ☐ Pending ☐ Unknown

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U

If yes, symptom onset date (mm/dd/yyyy): __/__/____

CHECK ALL THAT APPLY:

Fever ☐ Y ☐ N ☐ U
- ☐ Yes, subjective ☐ No
- ☐ Yes, measured ☐ Unknown
- Highest measured temperature_____
- Fever onset date (mm/dd/yyyy):_____

Skin rash ☐ Y ☐ N ☐ U
- Onset date (mm/dd/yyyy):_____
- **Anatomic site rash began:**
  - ☐ Head
  - ☐ Trunk
  - ☐ Upper extremities
  - ☐ Lower extremities
- Observed by health care provider ☐ Y ☐ N ☐ U
- Duration of rash:_____
  - Unit: ☐ Hours ☐ Days ☐ Weeks
- **Location:**
  - ☐ All over the body (generalized)
  - ☐ Generalized, predomiately central/torso/back (centripetal)
  - ☐ Generalized, predominately face/hands/feet (centrifugal)
  - ☐ Localized/Focal
  - ☐ Palms and soles
  - ☐ Unknown
- **Appearance of rash** (choose all that apply):
  - ☐ Macular Papular ☐ Pustular ☐ Unknown
  - ☐ Petechial ☐ Bullous ☐ Vesicular

Skin itching (pruritis) ☐ Y ☐ N ☐ U

Cough ☐ Y ☐ N ☐ U
- **Onset date** (mm/dd/yyyy)_____

Conjunctivitis ☐ Y ☐ N ☐ U

Runny nose and/or teary eyes (coryza) ☐ Y ☐ N ☐ U

Koplik's spots (small white or bluish spots on the buccal mucosa) ☐ Y ☐ N ☐ U

Thrombocytopenia ☐ Y ☐ N ☐ U

Encephalitis ☐ Y ☐ N ☐ U

Otitis ☐ Y ☐ N ☐ U

Pneumonia ☐ Y ☐ N ☐ U

Diarrhea ☐ Y ☐ N ☐ U

Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐ Y ☐ N ☐ U
- **If yes, specify:** _____

MATERNAL INFORMATION

COMPLETE IF PATIENT IS A CHILD LESS THAN 12 MONTHS OF AGE:

Was the mother of this infant/child case diagnosed with this disease? ☐ Y ☐ N ☐ U
- If yes, date of diagnosis (mm/dd/yyyy):_____
- Time frame of diagnosis
  - ☐ Prior to pregnancy
  - ☐ During pregnancy
  - ☐ At delivery
  - ☐ After delivery
  - ☐ Before birth - exact period unknown
  - ☐ Time frame unknown

If date of birth is unknown, provide biologic mother's age in years:_____

Was the child breastfed? ☐ Y ☐ N ☐ U

Was the biologic mother born outside the US? ☐ Y ☐ N ☐ U
- If yes, country:_____
- Date of biologic mother's arrival in the US (mm/dd/yyyy):_____

Did the biologic mother ever have evidence of serological IgG immunity? ☐ Y ☐ N ☐ U
- Test date (mm/dd/yyyy):_____
- Result:
  - ☐ Positive
  - ☐ Negative
  - ☐ Equivocal
  - ☐ Unknown

Was the child's biologic mother immunized with vaccine against this specific disease? ☐ Y ☐ N ☐ U
- Type of vaccine:
  - ☐ MMR (combined vaccine)
  - ☐ Measles
  - ☐ Mumps
  - ☐ Rubella
- Vaccine date (mm/dd/yyyy):_____
- Source of vaccine information:
  - ☐ Patient's or Parent's verbal report
  - ☐ Physician
  - ☐ Medical record
  - ☐ Certificate of immunization record
  - ☐ Patient vaccine record
  - ☐ School record
  - ☐ Other
  - ☐ Unknown

CONTINUED

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State: _____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

Did patient have a travel history during the 4 days prior to onset of symptoms until 5 days after rash onset? ☐Y ☐N ☐U
Travel dates: From:_____until _____
To city:_____State: _____
To country:_____
Reason(s) for travel:
☐ Vacation / tourism ☐ Airline / Ship crew
☐ Organized tour ☐ Missionary or dependent
☐ Business related, specify _____ ☐ Refugee / Immigrant
☐ Military related ☐ Student / Teacher
☐ Visit to family / friends ☐ Unknown
☐ Peace corps ☐ Other_____
Mode(s) of transportation (check all that apply)
☐ Airplane
☐ Ship / boat / ferry
Cruise ship? ☐Y ☐N ☐U
Specify cruise line _____
☐ Train / subway
☐ On foot
☐ Bus/taxi/shuttle
☐ Automobile / motorcycle
☐ Other, specify:_____

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U
If yes, list person(s) and contact numbers:

VACCINE
Has patient/contact ever received measles-containing vaccine? ☐Y ☐N ☐U
If yes, number of doses received on or after first birthday: _____
If yes, date of vaccination #1
(mm/dd/yyyy) _____
Vaccine type:_____
Manufacturer: _____
Product/trade name: _____
Lot number:_____
If yes, date of vaccination #2(mm/dd/yyyy) _____
Vaccine type:_____
Manufacturer: _____
Product/trade name: _____
Lot number:_____
Vaccine date unknown ☐Y ☐N
If no, reason for inadequate vaccination:
☐ Religious exemption
☐ Medical exemption
☐ Medical contraindication
☐ Philosophical exemption (outside NC only)
☐ Laboratory evidence of previous disease
☐ Physician diagnosis of previous disease
☐ Under age for vaccination
☐ Parental refusal
☐ Missed opportunities
☐ Unknown
☐ Other, specify:_____
Source of vaccine information:
☐ Patient's or Parent's verbal report
☐ Physician*
☐ Medical record*
☐ Certificate of immunization record*
☐ Patient vaccine record*
☐ School record
☐ Other, specify:_____
☐ NCIR record
☐ Unknown

REASON FOR TESTING

Why was the patient tested for this condition?
☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household / close contact to a person reported with this disease
☐ Other, specify_____
☐ Unknown

PREGNANCY

Is the patient currently pregnant? ☐Y ☐N ☐U
Estimated delivery date (mm/dd/yyyy):_____
Give number of weeks gestation at onset of illness:_____
Did patient have prenatal care? ☐Y ☐N ☐U
Setting of prenatal care
☐ Public sector
☐ Private sector
☐ Unknown
Prenatal provider name: _____
Did patient attend family planning clinic prior to conception? ☐Y ☐N ☐U
Has the patient ever been pregnant? ☐Y ☐N ☐U
Total number of previous pregnancies by the biologic mother_____

TREATMENT

Did patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U
If yes, specify antibiotic name: _____
Dose _____
Date antibiotic began (mm/dd/yyyy):_____
Date antibiotic ended (mm/dd/yyyy):_____
Number of days taken: _____ ☐ Unknown
Has the patient ever received immune globulin? ☐Y ☐N ☐U
When was the last dose received? (mm/dd/yyyy):_____
Has this contact received immune globulin? ☐Y ☐N ☐U
Date received (mm/dd/yyyy):_____
Did the patient receive medical care for this illness? ☐Y ☐N ☐U
Specify level(s) of care (check all that apply):
☐ Outpatient
☐ Emergency department
☐ Inpatient
☐ Other_____
☐ Unknown

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____
_____
Duration of acute illness: _____
Died from this illness? ☐Y ☐N ☐U
Patient died in North Carolina? ☐Y ☐N ☐U
County of death:_____
Died outside NC? ☐Y ☐N ☐U
Specify where:_____
Autopsy performed? ☐Y ☐N ☐U
Facility where autopsy was performed:
_____
Patient autopsied in NC? ☐Y ☐N ☐U
County of autopsy:_____
☐ Autopsied outside NC, specify where:_____
Source of death information (select all that apply):
Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.
☐ Death certificate
☐ Autopsy report final conclusions
☐ Hospital/physician discharge summary
☐ Other:_____
Cause of death:_____
Death date (mm/dd/yyyy):_____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U
Specify _____
_____
Other underlying illness ☐Y ☐N ☐U
Please specify: _____
Was the patient receiving any of the following treatments or taking any medications?
Antibiotics ☐Y ☐N ☐U
For what medical condition?_____
Chemotherapy ☐Y ☐N ☐U
If yes, was therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____
Radiotherapy ☐Y ☐N ☐U
If yes, was therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____
H2 blockers, proton pump, or ulcer medication (e.g. Tagamet, Zantac, Omeprazole) ☐Y ☐N ☐U
If yes, was medication/therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____
Systemic steroids/corticosteroids, including steroids taken by mouth or injection ☐Y ☐N ☐U
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____
Immunosuppresive therapy, including anti-rejection therapy ☐Y ☐N ☐U
If yes, specify: _____
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____
Aspirin or aspirin-containing product ☐Y ☐N ☐U
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐ Y ☐ N

Check all that apply:

☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify

_____

Date control measures issued: _____

Date control measures ended: _____

Was patient compliant with control measures? ☐ Y ☐ N

Local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐ Y ☐ N

If yes, specify: _____

_____

Were written isolation orders issued? ☐ Y ☐ N

If yes, where was the patient isolated? _____

_____

Date isolation started? _____

Date isolation ended? _____

Was the patient compliant with isolation? ☐ Y ☐ N

Were written quarantine orders issued? ☐ Y ☐ N

If yes, where was the patient quarantined?

_____

Date quarantine started? _____

Date quarantine ended? _____

Was the patient compliant with quarantine? ☐ Y ☐ N

Notes:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 4 days prior to onset of symptoms until 5 days after rash onset did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐ Y ☐ N ☐ U

Name of facility: _____

Dates of contact: _____

During the 4 days prior to onset of symptoms until 5 days after rash onset, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify: _____

In what setting was the patient most likely exposed?

☐ Restaurant
☐ Home
☐ Work
☐ Child Care
☐ School
☐ University/College
☐ Camp
☐ Doctor's office/ Outpatient clinic
☐ Hospital In-patient
☐ Hospital Emergency Department
☐ Laboratory
☐ Long-term care facility /Rest Home
☐ Military
☐ Prison/Jail/Detention Center
☐ Place of Worship
☐ Outdoors, including woods or wilderness
☐ Athletics
☐ Farm
☐ Pool or spa
☐ Pond, lake, river or other body of water
☐ Hotel / motel
☐ Social gathering, other than listed above
☐ Travel conveyance (airplane, ship, etc.)
☐ International
☐ Community
☐ Other (specify)

_____

☐ Unknown

Does the patient have any other risk factors for this disease? ☐ Y ☐ N ☐ U

Specify: _____

TRAVEL/IMMIGRATION

The patient is:

☐ Resident North Carolina
☐ Resident of another state or US territory
☐ Foreign visitor
☐ Refugee
Refugee camp(s)? ☐ Y ☐ N ☐ U
Name of camp _____
Location of camp _____
Country of birth _____
Last country prior to arrival in US _____
Date of entry to US _____
☐ Recent immigrant
Country of birth _____
Last country prior to arrival in US _____
Date of entry to US _____
☐ Foreign adoptee
Country of birth _____
Last country prior to arrival in US _____
Date of entry to US _____
☐ None of the above

Was patient pregnant while traveling? ☐ Y ☐ N ☐ U

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

Name: _____

Did patient have contact with a person with travel history during the period of interest? ☐ Y ☐ N ☐ U

Contact's name: _____

Travel dates: From: _____ until _____

To city: _____

To state: _____

To country: _____

Is contact a:

☐ Resident of another state or US territory
☐ Foreign visitor
☐ Recent immigrant
☐ Refugee
☐ Foreign adoptee
☐ Unknown
☐ Other, specify: _____

Notes:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U

Name of care provider: _____

Address: _____

City: _____ State: _____

Zip code: _____ County: _____

Contact name: _____

Telephone: (_____) _____

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U

Name of child care provider: _____

Address: _____

City: _____ State: _____

Zip code: _____ County: _____

Contact name: _____

Telephone: (_____) _____

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U

Name of child care provider: _____

Address: _____

City: _____ State: _____

Zip code: _____ County: _____

Contact name: _____

Telephone: (_____) _____

Is patient a student? ☐ Y ☐ N ☐ U

Type of school:

☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)

Name: _____

Address: _____

City: _____ State: _____

Zip code: _____ County: _____

Contact name: _____

Telephone: (_____) _____

Specify grade: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U

Type of school

☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)

Name: _____

Address: _____

City: _____ State: _____

Zip code: _____ County: _____

Telephone: (_____) _____

Notes:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 4 days prior to onset of symptoms until 5 days after rash onset, did the patient have any of the following health care exposures?

Emergency Dept. (not hospitalized)... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Hospital ..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):_____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

LTC facility—resident..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):_____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Outpatient facility—patient..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Visitor to health care setting ..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):_____
- Until date (mm/dd/yyyy):_____
- Frequency:
  ☐ Once
  ☐ Multiple times within this time period
  ☐ Daily
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Worked or volunteered in health care or clinical setting ..... ☐ Y ☐ N ☐ U
- Facility name_____
- City_____State _____
- Country _____
- Occupation:
  ☐ Physician
  ☐ Physician's assistant or nurse practitioner
  ☐ Nurse
  ☐ Laboratory
  ☐ Other
  ☐ Unknown
- Specify work setting or volunteer duties:
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Other, specify_____

_____

Was patient employed in a laboratory? ..... ☐ Y ☐ N ☐ U

If yes, specify and give details: _____

_____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ..... ☐ Y ☐ N ☐ U

Who was interviewed?

Were health care providers consulted? ..... ☐ Y ☐ N ☐ U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
- City _____
- County_____

☐ Outside NC, but within US
- City _____
- State _____
- County_____

☐ Outside US
- City _____
- Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ..... ☐ Y ☐ N

Notes:

Measles (Rubeola)

2013 Case Definition

CSTE Position Statement(s): 12-ID-07

Clinical Description

An acute illness characterized by:

- Generalized, maculopapular rash lasting ≥3 days; **and**
- Temperature ≥101°F or 38.3°C; **and**
- Cough, coryza, or conjunctivitis.

Case Classification

Probable

In the absence of a more likely diagnosis, an illness that meets the clinical description with:

- No epidemiologic linkage to a confirmed case of measles; **and**
- Noncontributory or no measles laboratory testing.

Confirmed

An acute febrile rash illness† with:

- Isolation of measles virus‡ from a clinical specimen; or
- Detection of measles-virus specific nucleic acid‡ from a clinical specimen using polymerase chain reaction; or
- IgG seroconversion‡ or a significant rise in measles immunoglobulin G antibody‡ using any evaluated and validated method; or
- A positive serologic test for measles immunoglobulin M antibody‡ §; or
- Direct epidemiologic linkage to a case confirmed by one of the methods above.

† Temperature does not need to reach ≥101°F/38.3°C and rash does not need to last ≥3 days.

‡ Not explained by MMR vaccination during the previous 6-45 days.

§ Not otherwise ruled out by other confirmatory testing or more specific measles testing in a public health laboratory.

Case Classification Comment(s)

CDC does not request or accept reports of suspect cases so this category is no longer needed for national reporting purposes.

Epidemiologic Classification

Internationally imported case: An internationally imported case is defined as a case in which measles results from exposure to measles virus outside the United States as evidenced by at least some of the exposure period (7–21 days before rash onset) occurring outside the United States and rash onset occurring within 21 days of entering the United States and there is no known exposure to measles in the U.S. during that time. All other cases are considered U.S.-acquired.

U.S.-acquired case: An U.S.-acquired case is defined as a case in which the patient had not been outside the United States during the 21 days before rash onset or was known to have been exposed to measles within the United States.

U.S.-acquired cases are subclassified into four mutually exclusive groups:

- **Import-linked case:** Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.
- **Imported-virus case:** A case for which an epidemiologic link to an internationally imported case was not identified, but for which viral genetic evidence indicates an imported measles genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any measles virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.
- **Endemic case:** A case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of measles virus transmission that is continuous for ≥12 months within the United States.

Epidemiologic Classification, continued

- **Unknown source case:** A case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases.

States may also choose to classify cases as out-of-state-imported when imported from another state in the United States. For national reporting, however, cases will be classified as either internationally imported or U.S.-acquired.