



## Measles Case Investigation Form

Healthcare professionals (HCPs) have a legislative duty to report notifiable and reportable diseases to the Chief Public Health Officer (CPHO) as required in the [NWT Public Health Act](#) (2009, SNWT 2007, c.17, SI-007-2009), with required information and timelines for reporting as defined in the [Disease Surveillance Regulations](#) (2009, R-096- 2009). This information is used for territorial and national surveillance and informs public health planning and interventions.

<b>What and when to report:</b>	
<b>Heath Care Professionals:</b>	<ul style="list-style-type: none"><li>Suspect, probable and confirmed cases are to be reported to the Office of the Chief Public Health Officer (OCPHO) by telephone (867) 920-8646 <b>immediately</b> after diagnosis is made or opinion is formed, <b>AND</b></li><li><b>Immediately</b> report all outbreaks or suspect outbreaks by telephone to the OCPHO</li></ul>
<b>Laboratories</b>	<ul style="list-style-type: none"><li>Report all positive results to the OCPHO by fax (867) 873-0442 <b>immediately</b>.</li></ul>

<b>How to Report</b>	
Medical Confidential Fax	867-873-0442
Secure File Transfer (SFT)	cdcu@gov.nt.ca



## Measles Case Investigation Form

### SECTION 1 CASE IDENTIFICATION

Last Name:	First Name:
HCN:	Date of Birth:
Home Community:	Province/Territory: Other:
Sex assigned at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Unknown	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: <input type="checkbox"/> Unknown

### SECTION 2 CLINICAL INFORMATION

<b>Prodrome Symptoms:</b>		Date of onset:	<b>Maculopapular rash:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Date of onset: ____/____/____ Is the rash generalized
Coryza	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Duration (days): _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Other rash: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	Where did the rash start: _____
Koplik Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	<input type="checkbox"/> Face <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities _____

<b>Hospitalization:</b>		<b>Visited Out-Patient Clinics:</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Visit Date: ____/____/____	Clinic(s): _____	
If yes, hospital name: _____		Date Admitted: ____/____/____	_____
		Date Discharged: ____/____/____	Date: ____/____/____

<b>Clinical Outcome:</b>		Residual effects:	Fatal: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Recovered	<input type="checkbox"/> Without residual effects	<input type="checkbox"/> Otitis Media <input type="checkbox"/> Pneumoniae <input type="checkbox"/> Encephalitis	Date of Death: ____/____/____
<input type="checkbox"/> With residual effects	<input type="checkbox"/> Meningitis <input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diarrhea	Death Due to Measles/
	<input type="checkbox"/> Other: _____		Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Specimen Collected:</b>		<b>Date Collected:</b>	<b>Result:</b>	<b>History of Disease:</b>
<input type="checkbox"/> Nasopharyngeal swab (Measles PCR)		____/____/____/	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Urine (Measles PCR)		____/____/____/	_____	
<input type="checkbox"/> Serology (IgM/IgG)		____/____/____/	_____	

<b>Vaccine Name</b>	<b>Date Received</b>	<b>Province/Territory</b>	<b>Lot Number (if known)</b>
1.			
2.			

### SECTION 3 PUBLIC HEALTH ACTIONS/RECOMMENDATIONS

<b>Advice:</b> Date advised to self-isolate: End date for self-isolation: ____/____/____ / ____/____/____	<b>Immunoglobulin Received:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date: ____/____/____
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Health Card Number:

Last Name:

First Name:

#### SECTION 4 EXPOSURE INFORMATION

Name of employer: \_\_\_\_\_

Does the patient attend daycare, school, or post-secondary institution?  Yes  No

If YES, Name of the school/institution: \_\_\_\_\_ Grade/level/year: \_\_\_\_\_

Last Day attended: \_\_\_\_/\_\_\_\_/\_\_\_\_/

What type of residence does the patient live in?

House  Apartment  University Residence  Hotel/Motel  Group Home

Name: \_\_\_\_\_

Long-Term Care Facility OR Other (please specify):  
\_\_\_\_\_  
\_\_\_\_\_

Exposure to known/suspect case of measles in the past 21 days:

Yes  No If yes, additional details: \_\_\_\_\_  
Date of onset: \_\_\_\_/\_\_\_\_/\_\_\_\_/

Travel History in the past 21 days	Date(s) DD/MMM/YYYY	Location	Conveyance
<input type="checkbox"/> Domestic			
<input type="checkbox"/> International			

#### Measles Disease Timelines:

##### Period of Communicability\*:

One day prior to the start of the prodrome\*\* until 4 days after rash onset

If prodrome onset is not well defined, consider the case contagious from 4 days before until 4 days after rash onset.

##### Prodrome\*\* to rash onset

Time from prodrome\*\* to rash onset is 3-7 days.

Rash may last 4-7 days.

##### Incubation Period

Time from exposure to prodrome (fever, coryza, conjunctivitis, cough and Koplik spots) averages 10 days with a range of 7-18 days. Time from exposure to rash onset averages 14 days with a range of 7-21 days.

##### Activity Details

Importance should be placed on naming activities that involve others such as events, restaurants, shopping, etc.

\*This is the period where contact tracing is the most important.

\*\*Prodrome is early symptoms which indicate the onset of illness or disease. For measles these include symptoms before rash onset such as fever, coryza, conjunctivitis, and cough.



Health Card Number:

Last Name:

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Day	Activity Details
Day -21	
Day -20	
Day -19	
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	
<b>Day 0 (Rash Onset)</b>	
Day 1	
Day 2	
Day 3	
Day 4	

Report date (DD/MM/YYYY):

Report completed by (please print):

Signature:

Office of the Chief Public Health Officer | Department of Health and Social Services

Phone: (867) 920-8646/ Fax: (867) 873-0442



Health Card Number:

Last Name:

First Name:

## OFFICE OF THE CHIEF PUBLIC HEALTH OFFICER (OCPHO) Recommendations/Notes:

OFFICE OF THE CHIEF PUBLIC HEALTH OFFICER (OCPHO) Recommendations/Notes:

**Signature:**

Date  
(DD/MM/YYYY):

## Reset Form

## Print Form

### Submit Via SFT

OCPHO Office Use Only

### Basis for classification:

Laboratory results     Epidemiological link     Clinical Presentation