



## 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.

| What and when to report:          |  |
|-----------------------------------|--|
| <b>Health 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>   |

| How to Report              |               |
|----------------------------|---------------|
| Medical Confidential Fax   | 867-873-0442  |
| Secure File Transfer (SFT) | cdc@gov.nt.ca |



## Measles Case Investigation Form

| SECTION 1 CASE IDENTIFICATION   |   |
|---|---|
| Last Name:  | First Name:   |
| HCN:  | Date of Birth:  |
| Home Community:   | Province/Territory: <span style="float: right;">Other:</span>   |
| 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><br>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="margin-left: 20px;">Date of onset: ___/___/___</span><br>Coryza <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="margin-left: 20px;">Date of onset: ___/___/___</span><br>Conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="margin-left: 20px;">Date of onset: ___/___/___</span><br>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="margin-left: 20px;">Date of onset: ___/___/___</span><br>Koplik Spots <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="margin-left: 20px;">Date of onset: ___/___/___</span> | <b>Maculopapular rash:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date of onset: ___/___/___ <span style="margin-left: 20px;">Is the rash generalized</span><br>Duration (days): _____ <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Other rash: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br>Where did the rash start: _____<br><input type="checkbox"/> Face <input type="checkbox"/> Trunk <input type="checkbox"/> Extremities |
| <b>Hospitalization:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <span style="margin-left: 20px;">Visit Date: ___/___/___</span><br><i>If yes, hospital name:</i> _____ <span style="margin-left: 20px;">Date Admitted: ___/___/___</span><br><span style="margin-left: 20px;">Date Discharged: ___/___/___</span>   | <b>Visited Out-Patient Clinics:</b><br>Clinic(s): _____<br>Date: ___/___/___  |
| <b>Clinical Outcome:</b><br>Recovered <input type="checkbox"/> Without residual effects <input type="checkbox"/> With residual effects<br>Residual effects:<br><input type="checkbox"/> Otitis Media <input type="checkbox"/> Pneumoniae <input type="checkbox"/> Encephalitis<br><input type="checkbox"/> Meningitis <input type="checkbox"/> Bronchitis <input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Other: _____   | Fatal: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br>Date of Death: ___/___/___<br>Death Due to Measles/<br>Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| <b>Specimen Collected:</b><br><input type="checkbox"/> Nasopharyngeal swab (Measles PCR) <span style="margin-left: 20px;">Date Collected: ___/___/___</span> <span style="margin-left: 20px;">Result: _____</span><br><input type="checkbox"/> Urine (Measles PCR) <span style="margin-left: 20px;">Date Collected: ___/___/___</span> <span style="margin-left: 20px;">Result: _____</span><br><input type="checkbox"/> Serology (IgM/IgG) <span style="margin-left: 20px;">Date Collected: ___/___/___</span> <span style="margin-left: 20px;">Result: _____</span>  | <b>History of Disease:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br><br><b>History of Immunization:</b><br>Received measles-containing vaccine in the past:<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |

| Vaccine Name | Date Received | Province/Territory | Lot Number (if known) |
|--------------|---------------|--------------------|-----------------------|
| 1.           |               |                    |                       |
| 2.           |               |                    |                       |

| SECTION 3 PUBLIC HEALTH ACTIONS/RECOMMENDATIONS  |   |
|--|---|
| <b>Advice:</b><br>Date advised to self-isolate: ___/___/___ <span style="margin-left: 20px;">End date for self-isolation: ___/___/___</span> | <b>Immunoglobulin Received:</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br>Date: ___/___/___ |



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:

First Name:

| 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

