Government of Northwest Territories | Gouvernement des Territoires du Nord-Ouest

Final Status: ☐ Confirmed ☐ Probable ☐ Ruled Out
Index Case: ☐ Yes ☐ No ☐ Unknown
Secondary Case: ☐ Yes ☐ No ☐ Unknown
OCPHO office use only

NWT MEASLES CASE INVESTIGATION FORM

SECTION 1 CASE IDENTIFICATION

Personal Health Number:	Date of Birth: Sex: ☐ Male ☐ Female Other ☐
Last Name:	First Name:

SECTION 2 CLINICAL INFORMATION

Symptoms:

Maculopapular rash ☐ Yes ☐ No
Date of onset:____/____/_____ Where did rash start? ☐ Face ☐ Trunk ☐ Extremities
Duration (days): _____ Is rash generalized? ☐ Yes ☐ No ☐ Unknown
Fever ☐ Yes ☐ No
Date of onset:____/____/_____ Max Temp: _____ ºC ☐ Oral ☐ Rectal ☐ Axillary

Coryza ☐ Yes ☐ No
Conjunctivitis ☐ Yes ☐ No
Cough ☐ Yes ☐ No

Hospitalization:
☐ Yes ☐ No ☐ Unknown
Visited Out-patient clinic: ☐ Yes ☐ No ☐ Unknown

If yes,
Hospital Name: _____
Clinic Name: _____

Date admitted: ____/___/_____
Date Discharged:____/___/_____
Visit Date:____/____/_____

Clinical Outcome:
Recovered
☐ without residual effects
☐ with residual effects

Residual effects:
☐ Otitis Media ☐ Pneumoniae ☐ Encephalitis
☐ Meningitis ☐ Bronchitis ☐ Diarrhea
☐ Other_____

Fatal: ☐ Yes ☐ No ☐ Unknown
Date of Death:____/____/_____
Death Due to Measles/ Complications: ☐ Yes ☐ No

Treatment:
☐ MMR Dose 1 ___/___/_____
☐ MMR Dose 2 ___/___/_____
☐ Immunoglobulin ___/___/____
☐ Not applicable (considered immune)

Specimen Collected:
☐ Nasopharyngeal swab (Measles PCR)
☐ Serum (Measles IgG/IgM)
☐ Urine (Measles PCR)

Date Collected:
_____/_____/_____
_____/_____/_____
_____/_____/_____

Advice:
☐ Self Isolation (21 days post exposure)
End date :
_____/_____/_____
OR
☐ Considered immune

SECTION 3 HISTORY OF IMMUNIZATION

History of measles disease:
☐ Yes ☐ No ☐ Unknown

Received measles-containing vaccine in the past:
☐ Yes ☐ No ☐ Unknown

If no immunization, specify why:

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

SECTION 4 EXPOSURE INFORMATION

Occupation: _____ Name of Employer: _____

Do you attend a day care, school or post-secondary institution? ☐ Yes ☐ No

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

What type of residence do you live in?

☐ House ☐ Apartment ☐ University residence ☐ Hotel/Motel ☐ Group Home or Long-Term Care Facility

☐ Other (please specify)_____

Health Card Number:	Last Name:	First Name:

Do you live, room or share accommodation with anyone? ☐ Yes ☐ No If YES, with how many people? _____

Do you receive home care? ☐ Yes ☐ No

Have you had contact with anyone who was told they have measles? ☐ Yes ☐ No

If yes, Name of Person: _____

Social activities in the 21 days before case developed symptoms

Social Activities in past 21 days	Date(s) YYYY/MM/DD	Activity Details
☐ Used public transit		
☐ Visited or volunteered at a hospital		
☐ Attended church/religious function		
☐ Attended family gathering		
☐ Attended meeting or conference		
☐ Attended concert, theatre or sports event		
☐ Participated in shopping event		
☐ Participated in recreational activity		
☐ Dined at coffee shop/cafeteria/food court		
☐ Dined at restaurant		
☐ Patronised bar or night club		
☐ Other activities		

Travel History in past 21 days	Date(s) YYYY/MM/DD	Location	Conveyance
☐ Domestic			
☐ International			

Close Contact Information (ONLY COMPLETE UPON RECOMMENDATION FROM OPCHO)

Please list all close contacts, including your spouse, partner, siblings, children, family members, roommates and other people you live with

Contact Name (Surname, Given Name)	**Relationship**	**Date of Birth (or Age)** YYYY/MM/DD	**Immunization Status** Not immunized (0), 1 dose (1), 2 dose (2), History of measles (3)	**Occupation**

Health Card Number:	Last Name:	First Name:

Rash Incubation Period

Fever Incubation Period

Period of Communicability

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	
Day 0 (Rash Onset)	
Day 1	
Day 2	
Day 3	
Day 4	
Day 5	
Day 6	
Day 7	

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:

Basis for classification:	
Laboratory results	☐
Epidemiological link	☐
Clinical Presentation	☐
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OFFICE OF THE CHIEF PUBLIC HEALTH OFFICER (OFPHO) Recommendations/Notes:	
Signature:	**Date (DD/MM/YYYY):**