NATIONAL EPIDEMIOLOGY BRANCH

NATIONAL SURVEILLANCE UNIT, NATIONAL EPIDEMIOLOGY BRANCH,
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MINISTRY OF HEALTH & WELLNESS

FEVER AND RASH INVESTIGATION

INITIAL DIAGNOSIS

☐ Measles ☐ Rubella ☐ Other Rash Illness Specify:_____

Date of Notification: DD/MM/YYYY	Date Investigation Started: DD/MM/YYYY

PATIENT'S DEMOGRAPHICS

Patient's ID Type: ☐ Driver's License ☐ TRN ☐ Passport ☐ NIN	Patient's ID Number:
First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Patient's Maiden Name (if applicable):	
Sex Assigned at Birth: ☐ Male ☐ Female	Medical Record Number:
Date of Birth: DD/MM/YYYY	Age:
Country of Residence:	Parish (Jamaica):
House Number, Street Name:	
Landmark or directions to address:	Community:
Phone Number:	Email Address:

Occupation:	
Name of Workplace/School:	
Address of School/Workplace:	
Phone Number:	Email Address:

NEXT OF KIN

First Name:	Last Name:
Pet Name(s):	
Address: Lot/ Street/Community/Parish:	
Phone number:	Email address:

Relationship to the Patient:

☐ Wife	☐ Son	☐ Uncle	☐ Cousin
☐ Husban	☐ Daughter	☐ Aunt	☐ Friend
☐ Mother	☐ Sister	☐ Grandmother	☐ Guardian
☐ Father	☐ Brother	☐ Grandfather	☐ Other (specify):

VACCINATION HISTORY

Type of Vaccine	Number of doses	Date of last dose	Source of vaccination Information (Vaccination Card, Medical Record, Verbal)
Measles		DD/MM/YYYY	
Rubella		DD/MM/YYYY	
Measles, Rubella		DD/MM/YYYY	
Measles, Mumps, Rubella		DD/MM/YYYY	

FEVER AND RASH INVESTIGATION

MEDICAL RECORD NUMBER:

CLINICAL PROFILE

Date Seen: DD/MM/YYYY | Date of Home Visit: DD/MM/YYYY

☐ History of Fever ☐ Recorded Fever ☐ No History of Fever or Recorded Fever ☐ Unknown

Recorded temperature: | Duration (days): | Date of Onset: DD/MM/YYYY

☐ Maculopapular Rash ☐ Vesicular Rash ☐ No History of Rash ☐ Unknown

If other Rash (Specify):

Duration (days): | Date of Onset: DD/MM/YYYY

☐ Cough	☐ Coryza	☐ Conjunctivitis
☐ Koplik Spots	☐ Lymphadenopathy	☐ Arthralgia
☐ Other Unlisted Symptoms:		

MEDICAL HISTORY

Pre-existing Conditions

☐ Asthma	☐ Diabetes mellitus	☐ HIV/AIDS	☐ Malignancy
☐ Autoimmune	☐ Heart disease	☐ Hypertension	☐ Sickle cell disease
☐ Chronic Obstructive Pulmonary Disease (COPD)	☐ Kidney disease	☐ Liver dysfunction	☐ Other (Specify):

PREGNANCY

Is Patient Pregnant: ☐ Yes ☐ No ☐ Unsure ☐ Not Applicable

Gestational Age: Trimester: ☐ First ☐ Second ☐ Third

HOSPITAL SUMMARY

Admitted to Hospital? ☐ Yes ☐ No	Date of Admission: DD/MM/YYYY	Date of Discharge: DD/MM/YYYY
Hospital:	Ward:	Medical Record Number:
Vital Status(Outcome): ☐ Alive Dead	Date of Death: DD/MM/YYYY	Time of Death: __:__ AM/PM

Place of Death: ☐ Home ☐ Dead on Arrival ☐ Ward ☐ ICU ☐ Other, Specify: _____

SAMPLE AND LAB INFORMATION

Was a sample taken? ☐ Yes ☐ No ☐ Unsure

If yes, what specimen was taken?

☐ Serum ☐ Nasopharyngeal Swab ☐ Urine

Other, Specify: _____

What date was the specimen taken? DD/MM/YYYY

Which lab is the sample being sent to?

☐ National Public Health Laboratory ☐ University of the West Indies ☐ Other

Specify Other Laboratory:

FEVER AND RASH INVESTIGATION

MEDICAL RECORD NUMBER:

LAB TEST(S) REQUESTED	LAB RESULT(S)				DATE RESULT RECEIVED
☐ Measles IgM	☐ Positive	☐ Negative	☐ Indeterminate	☐ Unknown	DD/MM/YYYY
☐ Measles IgG	☐ Positive	☐ Negative	☐ Indeterminate	☐ Unknown	DD/MM/YYYY
☐ Rubella IgM	☐ Positive	☐ Negative	☐ Indeterminate	☐ Unknown	DD/MM/YYYY
☐ Rubella IgG	☐ Positive	☐ Negative	☐ Indeterminate	☐ Unknown	DD/MM/YYYY
☐ Viral Culture	☐ Positive	☐ Negative	☐ Indeterminate	☐ Unknown	DD/MM/YYYY
☐ Viral Genotype	Specify Genotype:				DD/MM/YYYY
☐ RT-PCR	☐ Positive	☐ Negative	☐ Indeterminate	☐ Unknown	DD/MM/YYYY
☐ Other, Specify:	☐ Positive	☐ Negative	☐ Indeterminate	☐ Unknown	DD/MM/YYYY

CASE MANAGEMENT AND INVESTIGATION

Were active case searches conducted? ☐ Yes ☐ No ☐ Unknown

Was the patient in contact with any pregnant woman? ☐ Yes ☐ No ☐ Unknown

Are there other cases present in the case's community of residence? ☐ Yes ☐ No ☐ Unknown

Travelled in the Last 7-23 weeks: ☐ Yes ☐ No ☐ Unknown

If travelled: ☐ Domestic Travel ☐ International Travel ☐ Domestic and International Travel

If travelled, fill out the table below:

COUNTRY VISITED	CITY VISITED	DATE ARRIVED IN COUNTRY	DATE DEPARTED COUNTRY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY
		DD/MM/YYYY	DD/MM/YYYY

Date returned to Jamaica DD/MM/YYYY

Setting where patient was suspected to have been infected and names of ill contacts
(SETTING = Household Contact, Health Facility, Work, Community, Conveyance, Other)

NAME	DATE OF CONTACT	CONTACT SETTING
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	

RESPONSE MEASURES

Ring vaccination completed? ☐ Yes ☐ No ☐ Unknown

Was rapid coverage monitoring done? ☐ Yes ☐ No ☐ Unknown

Cases followed up for 30 days after rash onset? ☐ Yes ☐ No ☐ Unknown

FEVER AND RASH INVESTIGATION

MEDICAL RECORD NUMBER:

CLASSIFICATION

INDEX DIAGNOSIS: MEASLES/RUBELLA	**FINAL DIAGNOSIS:**
VARIANTS (IF APPLICABLE):	

Case classification:

☐ Laboratory Confirmed	☐ Probable	☐ Pending
☐ Inconclusive	☐ Discarded	

Reason for classification:

Is the case epidemiologically linked? ☐ Yes ☐ No ☐ Unknown

Aetiology Category: ☐ Imported case ☐ Import-related cases ☐ Endemic ☐ Vaccine Associated ☐ Unknown

Source country (If Imported or Import-Related):

DEATH CLASSIFICATION

Measles/Rubella related death: ☐ Yes ☐ No ☐ Unknown

Immediate Cause:

Intermediate Cause:

Underlying Cause:

Investigator's Comments:

Investigator's Details

Date Investigation Completed: DD/MM/YYYY

First Name:

Last Name

Professional Group:

Phone number:

Email Address:

Name of Institution:

Community:

Parish:

Investigator's Office Number/Street Name:

Investigator's Health Region:

Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): DD/MM/YYYY