Measles Case Investigation Form

(1st copy to be sent to laboratory with specimen, 2nd copy to EDO (Health) office and 3rd copy to be kept in the reporting health facility)

PART I : For Use by Reporting Facility and EDO

Name of Reporting Health Facility: _____

Address of Health Facility: _____

Union Council: _____ Tehsil/Taluka/Town: _____

District: _____ Province/Area: _____

Date Patient Visited Hospital: _____/_____/_____

Case ID number: (to be filled at district) **PAK** | | | | | | | | **Msl** | | | | |

Patient's Name : _____ Sex: Male _____ Female _____

Father's Name: _____

Date of Birth : _____/_____/_____ Age: Years _____ Months _____

Address of Patient :

Village/Street/Mahalla

Union Council: _____ Tehsil/Taluka/Town: _____

District: _____ Province/Area: _____

Date of Rash onset: _____/_____/_____

Number of Measles vaccine doses received (circle): **Nil** **One** **Two**

Date of last dose of measles vaccination: _____/_____/_____

Type of specimen (circle):	**Oral swab**	**Throat swab**	**Blood**
Date of Specimen Collection :	_____/_____/_____	_____/_____/_____	_____/_____/_____
Date of Specimen Sent to Lab :	_____/_____/_____	_____/_____/_____	_____/_____/_____

Lab Result to be Sent to: (EDO-H, DSC/SO-WHO, Provincial and Federal officials) and

Name : _____

Address: _____

Telephone/FAX: _____ **Email:** _____

Name of person completing the form: _____

Designation: _____

Signature: **Date:** _____/_____/_____

PART II: For Use by Receiving Laboratory

Type of specimen (circle):		**Oral swab**	**Throat swab**	**Blood**
Date specimens received at lab:		_____/_____/_____	_____/_____/_____	_____/_____/_____
Lab Number:				
Condition of specimen:	Quantity Adequate:	Yes No	Yes No	Yes No
	Cold Chain OK:	Yes No	Yes No	Yes No
Specimen Received by:				
Name:				
Designation:				
Date of Lab Test done:		_____/_____/_____	_____/_____/_____	_____/_____/_____
Type of test done:				
Test result:				
Comment:				

Report sent by: **Name:** **Signature:**
Designation: **Date:**

Part III - 30-day Follow up (to be filled for outbreak cases)

Date of Follow Up : _____/_____/_____

Outcome: **Alive** **Dead**

Reported by: **Name:** **Signature:**
Designation: **Date:**