1. Patient Information

Case Identification Number: MR- _____/_____/_____/____/_____
Country code/ Province code/District code/ Year/serial number

Name of Health Facility:	(dd/mm/yyyy)
Patient Name:	Date of Birth: (_____/_____/_____)
Age in Year: _____ Month: _____	Date of Visit (_____/_____/_____)
Gender: ☐ Male ☐ Female	Date of Onset fever: (_____/_____/_____)
Resident address:	Date of onset of rash: (_____/_____/_____)
District:	Date of notification: (_____/_____/_____)
Contact Number of Patient/Parents Mobile No.:	Date of Investigation: (_____/_____/_____)

2. Vaccination Status (by card / history)

	No. of Doses	Date 1st dose	Date 2nd dose
Measles containing vaccine:	_____	(_____/_____/_____)	(_____/_____/_____)
Rubella containing vaccine:	_____	(_____/_____/_____)	(_____/_____/_____)

3. Clinical Information

Fever: ☐Yes ☐No ☐Unknown

Maculopapular Rash: ☐Yes ☐No ☐Unknown

Cough: ☐Yes ☐No ☐Unknown

Coryza: ☐Yes ☐No ☐Unknown

Conjunctivitis: ☐Yes ☐No ☐Unknown

Adenopathy: ☐Yes ☐No ☐Unknown
If yes, place……..

Arthralgia: ☐Yes ☐No ☐Unknown
If yes, joint……..

Pregnancies: ☐Yes ☐No ☐Unknown
If yes, weeks…….

Others:

4. Patient Status

Hospitalization? ☐Yes ☐No if yes, Name of Hospital:

Date of admission: (_____/_____/_____) Date of discharge: (_____/_____/_____) Final status: ☐

Recovered ☐ Referred ☐ Died ☐Unknown

5. Epidemiological Information

Any similar illness in family/community: ☐Yes ☐No If yes, number……..

Travel History (7-21 days before the onset of rash): ☐Yes ☐No If yes, place/country visited:

Travel dates: From (_____/_____/_____) To (_____/_____/_____)

Name of Clinician: **Contact #**

6. Laboratory Information

To be filled at specimen collection point	To be filled by Testing Laboratory
A. Serology Samples and Test Results	
Specimen Collected? ☐ Yes ☐ No If yes, types of Specimen: ☐ Serum ☐ DBS Date of Collection: (_____/_____/_____) Specimen Collected By: Sample Shipment date: (_____/_____/_____) Sample sent by:	Date of sample received: (_____/_____/_____) Sample received by: Sample status: ☐ Satisfactory ☐ Unsatisfactory If unsatisfactory, give details: **Serology Result:** Specimen ID:_____ Test Done by: Date of Test: (_____/_____/_____) Date of Report to VPDP: (_____/_____/_____) Measles: ☐ Positive ☐ Negative ☐ Equivocal ☐ Test Not done Rubella: ☐ Positive ☐ Negative ☐ Equivocal ☐ Test Not done
B. Virology samples and Test Results	
Specimen Collected? ☐ Yes ☐ No If yes, types of Specimen: ☐ Throat swab ☐ Urine ☐ Other: Date of Collection: (_____/_____/_____) Specimen Collected By: Sample Shipment date: (_____/_____/_____) Sample sent by:	Date of sample received: (_____/_____/_____) Sample received by: Sample status: ☐ Satisfactory ☐ Unsatisfactory If unsatisfactory, give details: **Virology Result:** Specimen ID:_____ Test Done by: Date of Test: (_____/_____/_____) Date of Report to VPDP: (_____/_____/_____) ☐ Measles Positive ☐ Rubella Positive ☐ Negative ☐ Test Not done
C. Genotyping	
Specimen submitted for genotype. ☐ Yes ☐ No If yes, Date specimen sent: (____/_____/_____)	Genotype results: Measles: ____ Rubella:_____ Date results received by RCDC: (____/____/_____) Date results received by VPDP: (____/____/_____)

7. Classification (to be filled jointly by VPVD Lab, VPDP and NADSAE, RCDC)

Final Classification: ☐ Confirmed Measles ☐ Confirmed Rubella ☐ Discarded

Basis for classification: ☐ Laboratory ☐ Epidemiological Linked ☐ Clinical

Source of infection: ☐ Endemic ☐ Imported ☐ Import-related ☐ Unknown

Reason for discard……

8. Follow-up

Active case search done? ☐ Yes ☐ No If yes, number of additional suspected cases detected: _____

Outcome at 30 days follow-up: : ☐ Alive ☐ Died ☐ Lost to follow-up

Name of Laboratory person: **Contact #**