BC Centre for Disease Control

Epidemiology Services
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Measles Case Report Form

Please complete the following information and **fax** it **to (604) 660-0197.**

HEALTH AUTHORITY INFORMATION	
Date of Report: _____/_____/_____ (*yyyy/mm/dd*)	Health Authority:
Person Reporting:	Phone: ( )
PATIENT INFORMATION	
Last Name:	First Name:
Sex: ❑ Male ❑ Female	PHN:
Community of Residence:	Date of Birth: _____/_____/_____ (*yyyy/mm/dd*)
CLINICAL INFORMATION	
Rash Onset Date: _____/_____/_____ (*yyyy/mm/dd*)	Date Investigation Initiated by Health Unit: _____/_____/_____ (*yyyy/mm/dd*)
Case Diagnosis: ❑ Clinical ❑ Laboratory Confirmed ❑ Epidemiologically Linked	
Date Specimen Collected: _____/_____/_____ (*yyyy/mm/dd*)	Hospitalized? ❑ Yes ❑ No
Exposure: ❑ Inside Canada *(Specify Place of Exposure, e.g. school, daycare)* _____ ❑ Outside Canada *(Specify Country(s) visited during 4-18 days prior to onset of symptoms*) _____	
Vaccine History: ❑ Yes ❑ No ❑ Unknown If Yes, specify date doses were given: Dose 1: _____/_____/_____ (*yyyy/mm/dd*) Dose 2: _____/_____/_____ (*yyyy/mm/dd*)	
Outbreak Associated? ❑ Yes ❑ No	