

# MEASLES

## HEALTH CARE PROVIDER INVESTIGATION & REPORTING FORM

If measles is suspected or diagnosed, completion of this form is required and faxed by the SAME day as the initial patient visit, to the Windsor-Essex County Health Unit (fax: 226-783-2132).

\*\* Patients with suspected measles should be **IMMEDIATELY ISOLATED** in a negative-pressure room with door closed. If you do not have one, patient should wear a surgical mask and placed in a single room with door closed. Because measles virus can remain airborne for two hours, no other patient should use the room for **at least two hours after**. \*\*

**It is essential to complete ALL of the following tests to confirm diagnosis:**

SPECIMEN COLLECTION*		
Specimen Type / Date Collected	Collection Kit	Collection Requisition on Lab Requisition Form
<b>Nasopharyngeal swab/aspirate or throat swab</b> collected within 4-7 days after rash onset <i>Date Collected (YY/MM/DD):    /    /</i>	Universal transport medium (UTM) collection kit (pink medium)	Request " <b>Nasopharyngeal, Measles Virus Detection</b> " or " <b>Throat, Measles Virus Detection</b> ", including symptoms and onset date
<b>ACUTE blood specimen 5mL</b> collected within 7 days after rash onset <i>Date Collected (YY/MM/DD):    /    /</i>	Blood, clotted – vacutainer tubes (SST)	Request " <b>Blood, Acute Measles IgG/IgM Diagnosis</b> ", including symptoms and onset date
<b>For follow-up, CONVALESCENT blood specimen 5mL</b> collected 7-10 days after rash onset <u>AND</u> minimum 5 days after acute sample <i>Date Collected (YY/MM/DD):    /    /</i>	Blood, clotted – vacutainer tubes (SST)	Request " <b>Blood, Convalescent Measles IgG/IgM Diagnosis</b> ", including symptoms and onset date
<b>Clean catch urine 50mL</b> collected within 14 days after rash onset* <i>Date Collected (YY/MM/DD):    /    /</i>	Sterile container	Request " <b>Urine, Measles Virus Detection</b> ", including symptoms and onset date

\* If high index of suspicion for measles (e.g. compatible illness in a returned traveler) and beyond above time periods for specimen collection, call **Public Health Lab Service Desk (1-877-604-4567)** for collection requirements. The Service Desk is also available to answer questions regarding general specimen collection.

PATIENT INFORMATION		
Date (YY/MM/DD):	Name and contact number of reporting health care provider:  (    ) -    ext.	
Name of Client:		
(First)	(Middle)	(Current last) (Last while in elementary school)
Date of Birth: (YY/MM/DD)	Age:	Sex:
Address:		
(Street)	(City)	(Postal Code)
Home Phone: (    )	Alternate Phone: (    )	
School/Daycare/Workplace (if applicable):		
Name of Parent/Guardian (if applicable):		

### PATIENT EDUCATION

<input type="checkbox"/>	Client should <b>self-isolate</b> (exclude from work, school, daycare, and other group settings, and non-household contacts) for 4 days after onset of rash.
<input type="checkbox"/>	If medical attention is needed, client/parent should notify facility ahead of time that they are coming and measles are suspected. <i>This is to allow the facility to take precautions.</i>
<input type="checkbox"/>	Advise client/parent to inform exposed vulnerable contacts (i.e., pregnant, immunocompromised or susceptible to measles) of the need to follow up with a health care provider. It is up to the client/parent to decide if they want to inform contacts.
<input type="checkbox"/>	Inform client/parent that a nurse from the Health Unit will be contacting them.

PRESENTING SYMPTOMS			
√ Symptom	Onset Date (mm/dd)	√ Symptom	Onset Date (mm/dd)
<input type="checkbox"/> Fever		<input type="checkbox"/> Koplik's spots	
<input type="checkbox"/> Runny nose		<input type="checkbox"/> Drowsiness	
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Irritability	
<input type="checkbox"/> Conjunctivitis		<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Productive cough		<input type="checkbox"/> Respiratory problems	
<input type="checkbox"/> Non-productive cough		<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Macupapular rash		<input type="checkbox"/> Otitis media	
<input type="checkbox"/> Photophobia		<input type="checkbox"/> Muscle pain	

CASE INDEX OF SUSPICION				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Has the client been vaccinated against measles? *A measles-like rash occurring between 5-42 days after measles vaccination should be reported as an adverse event following immunization. Diagnostic lab work should be collected.			
	<b>Vaccine #</b>	<b>Name</b>	<b>Date Received (YY/MM/DD)</b>	<b>Lot #</b>
	1			
	2			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client travelled in the past 21 days?	Where: When:		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the client had exposure to someone with measles?	Who: Where:		

REPORTING HEALTH CARE PROVIDER'S SIGNATURE: \_\_\_\_\_

This form may be out of date. The most current form can be accessed on our website:

<https://www.wechu.org/health-care-providers/measles-reporting-form>.

The Health Protection and Promotion Act 1990 (HPPA), R.S.O., 1990, and Ontario Reg. 135/18, outlines the requirements for physicians, practitioners, and institutions to report any suspect or confirmed **disease of public health significance** to the Medical Officer of Health.