National Surveillance Unit, National Epidemiology Branch,
15 Knutsford Boulevard, Kingston 5,
Email: surveillance@moh.gov.jm, Telephone 876-633-7937

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):
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:
VACCINATION HISTORY	
Vaccination: ◯ Up to Date for Age ◯ Not up to Date ◯Unknown	

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	
		DD/MM/YYYY	
		DD/MM/YYYY	

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 History of Rash 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 Other:

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: | 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

Is the sample being sent to an external lab? ◯ Yes ◯ No

Select the laboratory to which the sample is being sent:

◯ National Public Health Laboratory	◯ CARPHA	◯ Other	

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 6 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 Centre, 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

Classification

Index Diagnosis: Fever and Rash **Final Diagnosis:**

Variants (If applicable):

Case classification:

◯ Laboratory Confirmed	◯ Probable	◯ Suspected
◯ Pending	◯ Inconclusive	◯ Discarded

Reason for classification:

Epidemiological Link:

◯ Human to human transmission	◯ Exposure to a common source	◯ Environmental exposure	◯ Laboratory Exposure

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

Source country (If Imported or Import-Related:

DEATH CLASSIFICATION

Contribution to patient death: ◯ Yes ◯ No ◯ Unknown

Immediate Cause:

Intermediate Cause:

Underlying Cause:

<table>
<tr><td colspan="3">Investigator’s Comments:</td></tr>
<tr><td colspan="3">Investigator’s Details</td></tr>
<tr><td colspan="3">Date Investigation Completed: DD/MM/YYYY</td></tr>
<tr><td colspan="3">First Name:</td></tr>
<tr><td colspan="3">Last Name</td></tr>
<tr><td colspan="3">Professional Group:</td></tr>
<tr><td colspan="3">Phone number:</td></tr>
<tr><td colspan="3">Email Address:</td></tr>
<tr><td colspan="3">Name of Institution:</td></tr>
<tr><td colspan="3">Community:</td></tr>
<tr><td colspan="3">Parish:</td></tr>
<tr><td colspan="3">Investigator’s Office Number/Street Name:</td></tr>
<tr><td colspan="3">Investigator’s Health Region:</td></tr>
<tr><td>Name of Parish MO(H):</td><td>Signature of MO(H):</td><td>Date signed by MO(H): DD/MM/YYYY</td></tr>
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