

New Zealand National Measles Laboratory Canterbury Health Laboratories

Measles Reporting form

To be completed only if case report form not completed

Measles Laboratory Request and Result Form			
Country:	Patient number:	Date:	
Patient name:			
Date of birth:	Age in months:	M <input type="checkbox"/>	F <input type="checkbox"/>
Name of parent or guardian:			
Address:			
VACCINATION HISTORY			
Number of doses of measles vaccine:		Date of last dose:	
CLINICAL HISTORY			
Travel history:			
Rash:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Onset date:
Fever:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Onset date:
Cough:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Runny Nose/Coryza:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Red Eyes/Conjunctivitis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Other Symptoms:			
Clinical Diagnosis:			
CONTACT HISTORY			
Household:			
School / Daycare:			
Other:			
SPECIMEN	DATE OF COLLECTION	DATE OF SHIPMENT	
(1)			
(2)			
(3)			
Name of person to whom laboratory results should be sent:			
Address:			
Telephone number:		Fax number:	

FOR USE BY THE RECEIVING LABORATORY					Reference ID No:
Laboratory ONLY					
INITIAL TESTING					
Name Testing Laboratory:					
Tests performed			Results		
Sent to Reference Laboratory Date:					
REFERENCE LABORATORY					
Name of Laboratory:					
Sample Received	Date Received	Test	Result	Comment	Report Issued

SUMMARY

Confirmed Measles: Yes No