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**Call 360-778-6100 during normal business hours or 360-715-2588 for the after-hours answering service.**

(Fax number: 360-778-6103)

**WAC (246-101-510) requires healthcare providers to immediately notify Public Health of suspect measles cases.** **The Whatcom Co. Health Department (WCHD) will need to submit this information to the WA State Department of Health (fax 206-364-1060) before specimens can be approved. Please complete as much information as possible prior to** **calling the WCHD to discuss your measles case. Thank you!**

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| --- | --- | --- | --- | --- |
| **Date Completed:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ **Name/Phone of LHJ contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Measles PHL Specimen Intake Form**  (can also be used for epi-linked cases without labs) | | | | |
| **Patient** | **Last name**: **First name**:                                                            **DOB**: **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_** **County of residence**: | | | |
| **Epidemiology** | **Date of Rash Onset:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_  **Did rash start on head or face?** □No □Yes  **Maculopapular rash?** □No □Yes  **Did fever overlap rash?** □No □Yes □No fever  **Was rash preceded (by 2 to 4 days) by at least one of: cough, runny nose, or red eyes?** □No □Yes | | **First Symptom Onset:** *(check all)*:  **□ Fever, Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_  **Highest Recorded Temp** \_\_\_\_\_\_\_°F  **□ Cough, Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_  **□ Runny nose (coryza), Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_  **□ Red eyes (conjunctivitis),**  **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | |
| **Was the patient hospitalized due to this illness?** □ Unk □ No □ Yes | | | |
| **Is patient immunized for measles?** □ Unk □ No □ Yes  Dates of measles vaccine doses: #1 \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ #3\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | |
| **Exposure History** | **Did the patient have known high risk exposure during the exposure period (7-21 days prior to rash onset)?**  □ Unk □ No □ Yes, detail: □ Confirmed measles case □ Travel □ Healthcare Visit □ Identified public venue  Date of first exposure: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ Date of last exposure: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_  Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Did the patient receive immune globulin as PEP?** □ Unk □ No □ Yes, date of IG: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_  **Did the patient receive MMR as PEP?** □ Unk □ No □ Yes, date of MMR: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | |
| **Specimen** | *For specimens inbound to PHL:*  **Which specimens were collected? □** NP **□** Serum **□** Urine **When were specimens collected?** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | |
| **Lab Results** | **Commercial Lab Results (if tested, retrieving specimen may be requested for PHL submission)** | | | |
| **Test** | **Result** | | **Date** |
| Measles IgM | **□** Pos **□** Neg **□** Equiv **□** Not done **□** Pending | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |
| Measles IgG | **□** Pos **□** Neg **□** Equiv **□** Not done **□** Pending | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ |
| **Notes** | **Notes:**  **(For WCHD only: Include specimen(s) tracking number)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |