

Supplementary Material. Measles case investigation form

1. Case identification			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of notification:/...../.....									
Date of investigation:/...../.....									
Source of notification: Health facility <input type="checkbox"/> Private clinic <input type="checkbox"/>									
Community <input type="checkbox"/> Active case finding <input type="checkbox"/> Other <input type="checkbox"/>									
2. Personal information									
Patient name: Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>									
Date of birth:/...../..... or Age:									
For children under 5 years, record age in months:									
Mother's (or father's) name:									
Address: House No. Street									
School/workplace address:									
Contact phone number:									
3. Medical history									
● Vaccination history (NIIS): Measles: Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>									
If yes, number of doses: Date of last dose: .../.../.....									
● Within 3 weeks before rash onset:									
Did the patient travel to another location? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>									
If yes, where:									
Did the patient have contact with a confirmed measles case? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>									
If yes:									
Who:									
Where: School <input type="checkbox"/> Community <input type="checkbox"/> Health centre <input type="checkbox"/>									
Were there any cases of fever and rash in the surrounding area? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>									
If yes:									
Who:									
Where: School <input type="checkbox"/> Community <input type="checkbox"/> Health centre <input type="checkbox"/>									
● Place of treatment: Hospital <input type="checkbox"/> Health centre <input type="checkbox"/> Private health facility <input type="checkbox"/> Home <input type="checkbox"/>									
● Outcome (death): Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date of death: .../.../.....									
4. Signs, symptoms and complications									
● Fever: Yes <input type="checkbox"/> No <input type="checkbox"/> Date of onset:/...../...					● Meningeal signs: Yes <input type="checkbox"/> No <input type="checkbox"/>				
● Rash: Yes <input type="checkbox"/> No <input type="checkbox"/> Date of onset:/...../...					● Encephalitis: Yes <input type="checkbox"/> No <input type="checkbox"/>				
● Cough: Yes <input type="checkbox"/> No <input type="checkbox"/>					● Pneumonia: Yes <input type="checkbox"/> No <input type="checkbox"/>				
● Runny nose: Yes <input type="checkbox"/> No <input type="checkbox"/>					● Otitis: Yes <input type="checkbox"/> No <input type="checkbox"/>				
● Conjunctivitis (red eyes): Yes <input type="checkbox"/> No <input type="checkbox"/>									
● Koplik spots: Yes <input type="checkbox"/> No <input type="checkbox"/>									
5. Laboratory specimens									
IgM antibody testing			Date of collection			Date sent			
● Serum sample 1: Yes <input type="checkbox"/> No <input type="checkbox"/>		/...../.....		/...../.....			
● Serum sample 2 (if required): Yes <input type="checkbox"/> No <input type="checkbox"/>		/...../.....		/...../.....			
6. Case classification									
Suspected cases <input type="checkbox"/>									
Confirmed cases <input type="checkbox"/>									
Discarded measles case <input type="checkbox"/>									