

MEASLES EXPOSURE INTERVIEW FORM (REV. 2/4/2015)

Last Name, First Name of Contact: _____
Phone/Best Number of Contact: ____ - ____ - _____
Address of Residence: _____
City: _____ **Zip Code:** _____
SPA: _____ **Health District:** _____
Date of Birth of Contact: ____ / ____ / _____ **Age** _____
Gender of Contact: _____
Parent Name (for children <18 years of age): _____
Occupation of Contact: _____
 Health care worker Yes No

Attempts to reach contact	Date & Time	Outcome of Call (disconnected, left message, wrong phone #, completed form, interviewed)
1 st Attempt		
2 nd Attempt		
3 rd Attempt		
4 th Attempt		
Interview		

Exposure Information:

Last Name, First Name to whom the contact was exposed: _____
 Exposure Site Name: _____

Exposure Setting Details: (If information below is already available, please complete before interviewing and confirm with contact).	
What is the exposure setting type? <input type="checkbox"/> Household <input type="checkbox"/> Daycare <input type="checkbox"/> Emergency department/ Hospital <input type="checkbox"/> Plane <input type="checkbox"/> Doctor's office <input type="checkbox"/> School <input type="checkbox"/> Other, please describe: _____	
Plane/Air Travel	Setting Location
Airline: Flight #: Departure City/Airport: Departure Date (mm/dd/yy): Arrival City/Airport: Arrival Date (mm/dd/yy): Index case seat #: Contact assigned seat #: Did contact sit in assigned seat? (Y/N): If no, what was the actual seat #?:	Location Name: Address: Health District: _____ Date (or last date) of exposure (mm/dd/yy):

Interviewer's Signature:
 Interviewer's Name:
 Date Completed:

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Immunity Information and Other Health Information

<i>Criteria</i>	<i>Yes</i>		<i>No</i>	<i>Unknown</i>	<i>Comments</i>
	Date of Diagnosis	Physician Diagnosed?			
Previous Measles					<input type="checkbox"/> Documented <input type="checkbox"/> Self-Reported
	Date of Dose #1	Date of Dose #2			
Received measles containing vaccine (i.e., MMR)					
If Yes: Documented? <input type="checkbox"/> <input type="checkbox"/> Self-Reported? <input type="checkbox"/> <input type="checkbox"/> If No: Personal Belief Exemption: <12 months old <input type="checkbox"/> Medical <input type="checkbox"/> Other, specify why <input type="checkbox"/>					
If you have not received a measles containing vaccine or unsure about it, do any of the following apply to your personal situation?	<input type="checkbox"/> Received a green card on or after 1996 <input type="checkbox"/> Born after 1970 and attended California Public Schools <input type="checkbox"/> Born before 1957 (see DOB information) <input type="checkbox"/> Ever served in the US military <input type="checkbox"/> Positive lab test for measles immunity (measles serology, or measles IgG) – this is typically done only if you are a healthcare worker				
<i>Criteria</i>	<i>Yes</i>		<i>No</i>	<i>Unknown</i>	<i>Comments</i>
	Specify type of intervention	Date Received			
Do you have a weakened immune system? Ex: HIV/AIDS, chemotherapy, leukemia, lymphoma, multiple myeloma, congenital immunodeficiencies, long-term use of high dose steroids, taking any type of medication that is meant to suppress the immune system, autoimmune disease	Describe condition:				
Are you pregnant?	How many weeks?				
	If yes, EDD:				

Interviewer's Signature:
 Interviewer's Name:
 Date Completed:

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<p>Do you routinely have contact with:</p> <p>Infants <1 year old</p> <p>Persons with weakened immune systems</p> <p>Pregnant women</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
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Collect Symptom Information

Date of interview	Fever		Rash	
	Yes Onset date Duration	No	Yes Onset date Duration	No

Comments:

INTERVENTIONS:

Please complete all fields)			
Was MMR given to this contact within 3 days of exposure? <input type="checkbox"/> Yes (Date: _____) <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Was IG given to this contact within 6 days of exposure? <input type="checkbox"/> Yes (Date: _____) <input type="checkbox"/> No <input type="checkbox"/> Not Applicable			
Was blood drawn on this contact for measles IgG testing? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Where was the blood sent for IgG testing?			
Date blood collected:	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal		
Is contact under active or passive monitoring? <input type="checkbox"/> Active <input type="checkbox"/> Passive			
Was contact interviewed at the end of the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Last day of Incubation Period:			
What specimens were collected?			
<input type="checkbox"/> Urine	Date Collected:	Lab:	Result:
<input type="checkbox"/> NP/Throat	Date Collected:	Lab:	Result:
<input type="checkbox"/> Blood	Date Collected:	Lab:	Result:
Was recommended/voluntary isolation directed for this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If not compliant, was legal order initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Interviewer's Signature:
 Interviewer's Name:
 Date Completed:

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