MEASLES EXPOSURE INTERVIEW FORM (LAC Revised 12/16)

HEALTH CENTER:_____ ID NUMBER:_____

PHN INSTRUCTIONS:

- ✓ **Please complete ALL information.**
- ✓ **If you have any questions regarding filling out this form, please contact the Immunization Program Surveillance Unit at 213-351-7800.**
- ✓ **QUESTIONS HIGHLIGHTED IN RED ( ) REQUIRE PHN FOLLOW UP AND COMPLETION BEYOND INITIAL CONTACT INTERVIEW OR INITIAL COMPLETION OF FORM.**

Thank you!

CONTACT/PATIENT INFORMATION (Questions 1-10)

1. **LAST NAME, FIRST NAME OF CONTACT: _____, _____**
2. **Phone/Best Number of Contact:** __ __ __ - __ __ __ - __ __ __ __
3. **Address of Residence**: _____
   City: _____ **Zip Code**: _____
4. **SPA:** _____
5. **Health District:** _____
6. **Date of Birth of Contact**: __ __ / __ __ / __ __ __ __ (MM/DD/YYYY)
7. **Age of Contact:** _____
8. **Gender of Contact:** ☐ Male ☐ Female ☐ Other
9. **Parent/Guardian Name (for children <18 years of age):** _____
10. **Occupation of Contact:** _____

EXPOSURE INFORMATION (Questions 11- 21)

**(complete this section prior to interview and confirm questions 15 through 21 with contact during interview)*

11. **Last Name, First Name of the case(s) to whom the contact was exposed**:
    _____, _____
12. **Exposure Date(s)**: _____(MM/DD/YYYY)
13. **END DATE OF INCUBATION PERIOD (*21 days after last exposure date to case while case was infectious*): _____** (MM/DD/YYYY)
14. **Exposure Setting/Site Name:** _____
15. **Address:** _____
    City: _____ **State:** _____ **Zip Code**: _____
16. **SPA:** _____
17. **Health District**: _____
18. **How long was the contact at this location?**

☐ Briefly (a few minutes) ☐ <1 hour ☐ 1-5 hours ☐ >5 hours ☐ Unknown

MEASLES EXPOSURE INTERVIEW FORM (LAC Revised 12/16)

HEALTH CENTER:_____ ID NUMBER:_____

19. **What is the exposure setting type?**

☐ Household
☐ Daycare
☐ Doctor's office
☐ Plane *(please complete question 20)*
☐ Emergency department/Hospital
☐ School
☐ Amusement Park, please specify: _____
☐ Other, please describe: _____

20. **Plane/Air Travel Information**

a. Contact did not travel by plane ☐
b. Airline: _____
c. Flight #: _____
d. Departure City/Airport: _____
e. Departure Date (MM/DD/YYYY): _____
f. Arrival City/Airport: _____
g. Arrival Date (MM/DD/YYYY): _____
h. Index case seat #: _____
i. Contact assigned seat #: _____
    i. Did contact sit in assigned seat? ☐ Yes ☐ No
        1. If no, what was the actual seat #: _____

21. **Was anyone else with contact at the exposure location?** ☐ Yes *(see below)* ☐ No ☐ Refused

(If yes, list name and phone # below and complete a form for each contact. If more space is needed, list additional contacts on the last page of the form.)

a) Name (Last, First)	Age	Phone #
b) Name (Last, First)	Age	Phone #
c) Name (Last, First)	Age	Phone #
d) Name (Last, First)	Age	Phone #
e) Name (Last, First)	Age	Phone #
f) Name (Last, First)	Age	Phone #
g) Name (Last, First)	Age	Phone #
h) Name (Last, First)	Age	Phone #
i) Name (Last, First)	Age	Phone #
j) Name (Last, First)	Age	Phone #

MEASLES EXPOSURE INTERVIEW FORM (LAC Revised 12/16)

HEALTH CENTER:_____ ID NUMBER:_____

IMMUNITY, PROPHYLAXIS AND LAB RESULTS (Questions 22- 29)

22. **Did contact previously have measles**? ☐ Yes *(answer section a)* ☐ No
    a. If yes: Date of Diagnosis (MM/DD/YYYY): _____
       Physician Diagnosed? ☐ Yes ☐ No

23. **Did contact previously receive measles containing vaccine (i.e., MMR)?**
    ☐ Yes *(answer section a)* ☐ No *(answer section b)* ☐ Unknown *(go to question 24)*
    a. If **Yes**:
       Self-Reported? ☐ Yes ☐ No
       Documented? ☐ Yes ☐ No
       Date of Dose #1 (MM/DD/YYYY): _____
       Date of Dose #2 (MM/DD/YYYY): _____
    b. If **No**, please specify reason:
       ☐ Personal Belief Exemption
       ☐ <12 months old
       ☐ Medical
       ☐ Unknown
       ☐ Other, specify why: _____

24. **If contact has not received a measles containing vaccine or is unsure about it, do any of the following apply to their personal situation? (Check all that apply)**
    ☐ Received a green card on or after 1996
    ☐ Born after 1970 and attended California Public Schools
    ☐ Born before 1957 (see DOB information)
    ☐ Ever served in the US military
    ☐ Positive lab test for measles immunity (measles serology, or measles IgG) – this is typically done only if you are a healthcare worker

25. **Has contact received any treatment related to exposure to measles (MMR, Immunoglobulin, etc.)?**
    ☐ Yes (type): _____ Date(MM/DD/YYYY): _____
    ☐ No
    ☐ Unknown

26. **Was MMR given to this contact within 3 days of exposure?**
    ☐ Yes – Date (MM/DD/YYYY): _____ ☐ Not Applicable
    ☐ No (Specify why not): _____

27. **Was IG given to this contact within 6 days of exposure?**
    ☐ Yes – Date (MM/DD/YYYY): _____ ☐ Not Applicable
    ☐ No (Specify why not): _____

28. **Was blood drawn on this contact for measles IgG testing?**
    ☐ Yes *(answer a-c)* ☐ No (Specify why not): _____
    a. Date blood collected (MM/DD/YYYY): _____
    b. Where was the blood sent for IgG testing? _____
    c. IgG Result: ☐ Positive ☐ Negative ☐ Equivocal

HEALTH CENTER:_____ **ID NUMBER:**_____

29. What additional specimens were collected from the contact?
☐ None (Specify why no other specimens collected): _____
☐ Urine (*only collect if contact is symptomatic*)
Date Collected (MM/DD/YYYY): _____
Lab testing specimens: _____
Result: ☐ Positive ☐ Negative ☐ Equivocal

☐ NP/Throat (*only collect if contact is symptomatic*)
Date Collected (MM/DD/YYYY): _____
Lab testing specimens: _____
Result: ☐ Positive ☐ Negative ☐ Equivocal

☐ Blood for IgM testing (*only test if contact is symptomatic*)
Date Collected (MM/DD/YYYY): _____
Lab testing specimens: _____
IgM Result: ☐ Positive ☐ Negative ☐ Equivocal

SYMPTOMS AND RISK FACTORS (Questions 30-36)

30. **Does the contact have a weakened immune system? (**Ex: HIV/AIDS, poorly regulated diabetes, chemotherapy, leukemia, lymphoma, multiple myeloma, congenital immunodeficiency, long-term use of high dose steroids, taking any type of medication that is meant to suppress the immune system, autoimmune disease.)
☐ Yes ☐ No ☐ Unknown

31. **Is the contact pregnant?** ☐ Yes - How many weeks? _____
☐ No
☐ Unknown

32. **Does the contact take any medications for asthma, lupus, psoriasis, rheumatoid arthritis?** (Examples: Enbrel, Humira, Rituximab, Stelara, chemotherapy, high dose steroids, other medications taken after an organ transplant) ☐ Yes (*answer section a*) ☐ No ☐ Unknown
a. What is the name, dosage and duration of the medication?
Name: _____ Dosage:_____ Duration:_____
Name: _____ Dosage:_____ Duration:_____
Name: _____ Dosage:_____ Duration:_____
Name: _____ Dosage:_____ Duration:_____
Name: _____ Dosage:_____ Duration:_____

MEASLES EXPOSURE INTERVIEW FORM (LAC Revised 12/16)

HEALTH CENTER:_____ ID NUMBER:_____

33. **Does the contact routinely have contact with:**
- Infants <1 year old? ☐ Yes ☐ No
- Persons with weakened immune systems? ☐ Yes ☐ No
- Pregnant women? ☐ Yes ☐ No

34. Was a legal order initiated to direct isolation of contact? ☐ Yes ☐ No

35. **Collect Symptom Information**

Date of interview	**Fever**		**Rash**		**Runny Nose**		**Cough**		**Conjunctivitis (red/pink eye)**	
	Yes Onset date & Duration (mm/dd/yyyy)	**No**	**Yes** Onset date & Duration (mm/dd/yyyy)	**No**	**Yes** Onset date & Duration (mm/dd/yyyy)	**No**	**Yes** Onset date & Duration (mm/dd/yyyy)	**No**	**Yes** Onset date & Duration (mm/dd/yyyy)	**No**
		☐		☐		☐		☐		☐
		☐		☐		☐		☐		☐
		☐		☐		☐		☐		☐
		☐		☐		☐		☐		☐
		☐		☐		☐		☐		☐
		☐		☐		☐		☐		☐

36. Was contact interviewed at the end of the incubation period? ☐ Yes ☐ No

EDUCATION (Questions 37-39)

37. **Did you (the PHN) provide the contact with information regarding signs and symptoms of measles and who to contact if signs and symptoms occur?** ☐ YES ☐ NO

*"Measles is very contagious. If you start to experience symptoms such as fever, runny nose, red eyes, or cough please contact us at **[insert phone number here]** right away. If you develop a rash please notify us immediately and stay at home to minimize your contact with others. You may also want to contact your doctor if you develop these symptoms. Please watch for symptoms until **[Insert end of incubation date here]**. We will check in with you at the end of this time period to determine that you're still well."*

38. **Did the contact have any information that would help with identifying further cases of measles?** ☐ YES (*specify below*) ☐ NO

MEASLES EXPOSURE INTERVIEW FORM (LAC Revised 12/16)

HEALTH CENTER:_____ ID NUMBER:_____

"Do you have any anything you would like to add that will help us contact individuals who may have been exposed to measles or individuals who may actually have measles illness?"

_____

_____

39. **Did the contact have any further questions?** ☐ YES (*specify below*) ☐ NO

*"Do you have any questions about measles that I can answer for you? If you think of any questions later please contact me at **[insert number here]**. Thank you!"*

_____

_____

_____

END INTERVIEW

Please remember to send completed interviews to [insert name and contact information here]

Please list any additional contacts from Question 21 below:

k) Name (Last, First)	Age	Phone #
l) Name (Last, First)	Age	Phone #
m) Name (Last, First)	Age	Phone #
n) Name (Last, First)	Age	Phone #
o) Name (Last, First)	Age	Phone #
p) Name (Last, First)	Age	Phone #
q) Name (Last, First)	Age	Phone #
r) Name (Last, First)	Age	Phone #
s) Name (Last, First)	Age	Phone #
t) Name (Last, First)	Age	Phone #
u) Name (Last, First)	Age	Phone #
v) Name (Last, First)	Age	Phone #
w) Name (Last, First)	Age	Phone #
x) Name (Last, First)	Age	Phone #