

Optional Measles, Mumps, or Rubella Air/Land Contact Investigation Outcome Reporting Form

1. PASSENGER CONTACT INFORMATION							
Last name, First name	Assigned seat	Actual/verified seat #	Sex	DOB (mm/dd/yyyy) OR	Age (yrs)	Country of birth	Country of residence
(Auto-populated)	(Auto-pop)						(Auto-pop, if available)
2. CONTACT INVESTIGATION OUTCOME FOR ABOVE NAMED PASSENGER CONTACT							
Were you able to contact this passenger? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes , date passenger was contacted: ___/___/___ How did you reach the passenger? (please check all that apply) <input type="checkbox"/> Telephone <input type="checkbox"/> Sent letter or visited in person <input type="checkbox"/> E-mail <input type="checkbox"/> Emergency Contact <input type="checkbox"/> Other (please specify): _____				If no , why could you not contact the passenger? (please check all that apply) <input type="checkbox"/> Incorrect locating info <input type="checkbox"/> No longer at temporary address <input type="checkbox"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> Other (please specify): _____			
(Continue)				(Stop here)			
Additional Comments: _____							
3. INTERVIEW INFORMATION							
Was contact interviewed? <input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction (specify) _____ <input type="checkbox"/> Other (specify) _____ (Stop here) <input type="checkbox"/> Yes (Continue)							
If contact is a woman of child-bearing age, is she pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes; what trimester at time of the flight? <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd							
4. HISTORY OF DISEASE OR VACCINE							
History of disease: <input type="checkbox"/> No <input type="checkbox"/> Yes; Approximate date ___/___/___ or age (yrs) ___ when had [this disease] <input type="checkbox"/> Unknown							
History of vaccination: <input type="checkbox"/> No <input type="checkbox"/> Yes; Number of doses of (disease auto-populated) -containing vaccine ____; <input type="checkbox"/> Unknown Approximate dates received: 1. ___/___/___ or age (yrs) received ____; 2. ___/___/___ or age (yrs) received ____; <input type="checkbox"/> Unknown							
5. MEASLES/RUBELLA: INTERVENTION RELATED TO EXPOSURE ON THE FLIGHT							
Did contact receive prophylaxis for this exposure to (disease auto-populated) ? <input type="checkbox"/> No <input type="checkbox"/> Yes If no, please check why not: <input type="checkbox"/> Outside window for prophylaxis <input type="checkbox"/> Within window for prophylaxis but declined <input type="checkbox"/> Other (specify): _____							
If yes, please check what she or he received and the date : <input type="checkbox"/> MMR or other (disease auto-populated) -containing vaccine; Date received: ___/___/___ <input type="checkbox"/> Immunoglobulin; Date received: ___/___/___							
6. MEASLES: HEALTH SINCE FLIGHT							
6a. FIRST INTERVIEW DONE ≤ 21 DAYS AFTER FLIGHT NOTE: If your first interview was after the incubation period (>21 days since the flight), please go to 6b Interview Date: ___/___/___ Did contact report any signs or symptoms? <input type="checkbox"/> No (Stop here) <input type="checkbox"/> Yes; please check all that apply: <input type="checkbox"/> Rash: Date of onset: ___/___/___ <input type="checkbox"/> Fever: Date of onset: ___/___/___, Max measured temperature _____°C/F <input type="checkbox"/> Feverishness (no temp measured): Date of onset: ___/___/___ <input type="checkbox"/> Cough: Date of onset: ___/___/___ <input type="checkbox"/> Coryza: Date of onset: ___/___/___ <input type="checkbox"/> Conjunctivitis: Date of onset: ___/___/___				6b. INTERVIEW DONE > 21 DAYS AFTER FLIGHT Interview Date: ___/___/___ <input type="checkbox"/> N/A (did not follow-up with contact after first interview) Did contact report any signs or symptoms? <input type="checkbox"/> No (Stop here) <input type="checkbox"/> Yes; please check all that apply: <input type="checkbox"/> Rash: Date of onset: ___/___/___ <input type="checkbox"/> Fever; Date of onset: ___/___/___, Max measured temperature _____°C/F <input type="checkbox"/> Feverishness (no temp measured): ___/___/___ <input type="checkbox"/> Cough: Date of onset: ___/___/___ <input type="checkbox"/> Coryza: Date of onset: ___/___/___ <input type="checkbox"/> Conjunctivitis: Date of onset: ___/___/___			

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6. MUMPS: HEALTH SINCE FLIGHT	
<p>6a. FIRST INTERVIEW DONE ≤ 25 DAYS AFTER FLIGHT NOTE: If your first interview was after the incubation period (>25 days since the flight), please skip to section 6b</p> <p>Interview Date: ___/___/___</p> <p>Did contact report any signs or symptoms? <input type="checkbox"/> No (Stop here) <input type="checkbox"/> Yes; please check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever; Date of onset: ___/___/___ , Max measured temperature _____°C/F <input type="checkbox"/> Feverishness (no temp measured): Date of onset: ___/___/___ <input type="checkbox"/> Parotitis: Date of onset: ___/___/___ <input type="checkbox"/> Upper respiratory symptoms: Date of onset: ___/___/___ Please describe symptoms _____ <input type="checkbox"/> Other: Date of onset ___/___/___ Please describe: _____ 	<p>6b. INTERVIEW DONE > 25 DAYS AFTER FLIGHT</p> <p>Interview Date: ___/___/___ <input type="checkbox"/> N/A (did not follow-up with contact after first interview)</p> <p>Did contact report any signs or symptoms? <input type="checkbox"/> No (Stop here) <input type="checkbox"/> Yes; please check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever; Date of onset: ___/___/___ , Max measured temperature _____°C/F <input type="checkbox"/> Feverishness (no temp measured): Date of onset: ___/___/___ <input type="checkbox"/> Parotitis: Date of onset: ___/___/___ <input type="checkbox"/> Upper respiratory symptoms: Date of onset: ___/___/___ Please describe symptoms _____ <input type="checkbox"/> Other: Date of onset ___/___/___ Please describe: _____
6. RUBELLA: HEALTH SINCE FLIGHT	
<p>6a. FIRST INTERVIEW DONE ≤ 23 DAYS AFTER FLIGHT NOTE: If your first interview was after the incubation period (>23 days since the flight), please skip to section 6b</p> <p>Interview Date: ___/___/___</p> <p>Did contact report any signs or symptoms? <input type="checkbox"/> No (Stop here) <input type="checkbox"/> Yes; please check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever; Date of onset: ___/___/___ , Max measured temperature _____°C/F <input type="checkbox"/> Feverishness (no temp measured): ___/___/___ <input type="checkbox"/> Rash: Date of onset: ___/___/___ <input type="checkbox"/> Coryza: Date of onset: ___/___/___ <input type="checkbox"/> Conjunctivitis: Date of onset: ___/___/___ <input type="checkbox"/> Arthralgia/arthritis: Date of onset: ___/___/___ <input type="checkbox"/> Lymphadenopathy: Date of onset: ___/___/___ 	<p>6b. INTERVIEW DONE > 23 DAYS AFTER FLIGHT</p> <p>Interview Date: ___/___/___ <input type="checkbox"/> N/A (did not follow-up with contact after first interview)</p> <p>Did contact report any signs or symptoms? <input type="checkbox"/> No (Stop here) <input type="checkbox"/> Yes; please check all that apply::</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever; Date of onset: ___/___/___ , Max measured temperature _____°C/F <input type="checkbox"/> Feverishness (no temp measured): ___/___/___ <input type="checkbox"/> Rash: Date of onset: ___/___/___ <input type="checkbox"/> Coryza: Date of onset: ___/___/___ <input type="checkbox"/> Conjunctivitis: Date of onset: ___/___/___ <input type="checkbox"/> Arthralgia/arthritis: Date of onset: ___/___/___ <input type="checkbox"/> Lymphadenopathy: Date of onset: ___/___/___
7. DIAGNOSIS (applicable for measles, mumps, AND rubella)	
<p>If contact reported symptoms, was s/he evaluated by a health care provider? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date(s): ___/___/___; ___/___/___</p> <p>If yes, was contact diagnosed with [this disease]? <input type="checkbox"/> No <input type="checkbox"/> Yes; Date: ___/___/___ <input type="checkbox"/> Insufficient Information</p> <p>How was diagnosis made? <input type="checkbox"/> IgM <input type="checkbox"/> Paired IgG <input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Epi-linked <input type="checkbox"/> Clinical diagnosis only <input type="checkbox"/> Other (specify): _____</p> <p>Did the infection develop within the incubation period? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Has anyone else developed [this disease] as a result of exposure to this person? <input type="checkbox"/> No <input type="checkbox"/> Yes; Who? _____</p> <p>Was this passenger a close contact of the index case other than on the flight? <input type="checkbox"/> No <input type="checkbox"/> Yes; type: <input type="checkbox"/> Household <input type="checkbox"/> Travel companion <input type="checkbox"/> Social <input type="checkbox"/> Work <input type="checkbox"/> Other _____</p> <p>Is this passenger a close contact with a known case of [this disease] other than the person on flight? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes; With whom? _____ Date of last exposure (mm/dd): ___/___</p> <p>Has contact visited other countries during the past month? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>If yes, list the country with the corresponding dates (mm/dd):</p> <ol style="list-style-type: none"> 1. _____ From: ___/___ to ___/___ 2. _____ From: ___/___ to ___/___ 3. _____ From: ___/___ to ___/___ 	
8. COMMENTS [free text field]	

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX