

Optional Measles, Mumps, or Rubella Maritime Contact Investigation Outcome Reporting Form

1. PASSENGER CONTACT INFORMATION						
Last name, First name	Cabin #	Sex	DOB (mm/dd/yyyy) OR	Age (yrs)	Country of birth	Country of residence
(Auto-populated)						
Was contact a passenger or crew member? <input type="checkbox"/> Passenger <input type="checkbox"/> Crew member, specify occupation _____						
2. CONTACT INVESTIGATION OUTCOME FOR ABOVE NAMED CONTACT						
Is contact still on this ship? <input type="checkbox"/> Yes, date due to disembark: __/__/____ <input type="checkbox"/> No, why not? <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> Transferred to another ship of the same company <input type="checkbox"/> Disembarked in another country (specify): _____ Location (specify address): _____ <input type="checkbox"/> Other; _____ <input type="checkbox"/>						
Additional comments:						
3. INTERVIEW INFORMATION						
Was contact interviewed? <input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <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 travel? <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd						
Is the contact immunocompromised? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____ <input type="checkbox"/> Unknown						
Relationship to index case: <input type="checkbox"/> Workmate <input type="checkbox"/> Cabinmate <input type="checkbox"/> Tablemate <input type="checkbox"/> Shared bathroom facilities <input type="checkbox"/> Other, specify _____						
Date of last exposure to index case: __/__/____						
Duration of contact with index case _____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days						
Did this person know of anyone else from the conveyance who may have developed this disease as a result of this exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes; Who? _____ <input type="checkbox"/> Unknown						
Did contact receive a notification letter from the ship? <input type="checkbox"/> No <input type="checkbox"/> Yes						
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], Was the diagnosis confirmed by a health care provider? <input type="checkbox"/> No <input type="checkbox"/> Yes <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"/> <input type="checkbox"/> <input type="checkbox"/> Unknown Is there written documentation of vaccination? <input type="checkbox"/> No <input type="checkbox"/> Yes Approximate dates or age received: 1. __/__/____ or age (yrs) received ____; 2. __/__/____ or age (yrs) received ____; <input type="checkbox"/> Unknown						
Serologic proof of immunity? <input type="checkbox"/> No <input type="checkbox"/> Yes; Is there written documentation? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Is the contact considered susceptible? <input type="checkbox"/> No <input type="checkbox"/> Yes						
5. MEASLES/RUBELLA: INTERVENTION RELATED TO EXPOSURE ON THE CONVEYANCE						
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: __/__/____						
Was contact quarantined alone? <input type="checkbox"/> No <input type="checkbox"/> Yes; /cohorted with others? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes, how many days? _____ <input type="checkbox"/> No						
6. MEASLES: HEALTH SINCE TRAVEL						
6a. FIRST INTERVIEW DONE ≤ 21 DAYS AFTER TRAVEL NOTE: If your first interview was after the incubation period (>21 days), please go to 6b Interview Date: __/__/____				6b. INTERVIEW DONE > 21 DAYS AFTER TRAVEL Interview Date: __/__/____ <input type="checkbox"/> N/A (did not follow-up with contact after first interview)		

Optional Measles, Mumps, or Rubella Maritime Contact Investigation Outcome Reporting Form

<p>Did contact report any signs or symptoms?</p> <input type="checkbox"/> No (Stop here)	<p>Did contact report any signs or symptoms?</p> <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: __/__/__	<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: __/__/__
6. MUMPS: HEALTH SINCE TRAVEL	
<p>6a. FIRST INTERVIEW DONE ≤ 25 DAYS AFTER TRAVEL NOTE: If your first interview was after the incubation period (>25 days), please skip to section 6b</p> <p>Interview Date: __/__/__</p> <p>Did contact report any signs or symptoms?</p> <input type="checkbox"/> No (Stop here)	<p>6b. INTERVIEW DONE > 25 DAYS AFTER TRAVEL</p> <p>Interview Date: __/__/__</p> <input type="checkbox"/> N/A (did not follow-up with contact after first interview)
<input type="checkbox"/> Yes; please check all that apply: <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: _____	<input type="checkbox"/> No (Stop here)
<input type="checkbox"/> Yes; please check all that apply: <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: _____	<input type="checkbox"/> Yes; please check all that apply: <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 TRAVEL	
<p>6a. FIRST INTERVIEW DONE ≤ 23 DAYS AFTER TRAVEL NOTE: If your first interview was after the incubation period (>23 days), please skip to section 6b</p> <p>Interview Date: __/__/__</p> <p>Did contact report any signs or symptoms?</p> <input type="checkbox"/> No (Stop here)	<p>6b. INTERVIEW DONE > 23 DAYS AFTER TRAVEL</p> <p>Interview Date: __/__/__</p> <input type="checkbox"/> N/A (did not follow-up with contact after first interview)
<input type="checkbox"/> Yes; please check all that apply: <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: __/__/__	<input type="checkbox"/> No (Stop here)
<input type="checkbox"/> Yes; please check all that apply: <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: __/__/__	<input type="checkbox"/> Yes; please check all that apply: <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 conveyance? <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 the conveyance? <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): 1. _____ From: __/__/__ to __/__/__ 2. _____ From: __/__/__ to __/__/__ 3. _____ From: __/__/__ to __/__/__</p>	

