

Measles Aircraft Contact Investigation Outcome Reporting Form

Return completed form by secure email to airadmin@cdc.gov (preferred) or fax to 404-471-8121 with the following text in the SUBJECT line:
Outcome Reporting Form DGMH ID #####

1. FLIGHT INFORMATION				
DGMH ID#	Arrival date	Departure city/airport	Arrival city/airport	Index case seat
2. INDEX CASE CLINICAL AND LAB INFORMATION				
3. CONTACT INFORMATION				
Last name, First name		Assigned seat	Gender	DOB (mm/dd/yyyy)/Age (yrs)
4. CONTACT/INTERVIEW INFORMATION				
Were you able to contact this person? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? <input type="checkbox"/> Incorrect locating information <input type="checkbox"/> No longer at temporary address but still in the U.S. <input type="checkbox"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> HD didn't attempt follow-up <input type="checkbox"/> Other, specify _____ (Skip to Section 9) If yes, date contacted: ___/___/___				
Was contact interviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction, specify: _____ <input type="checkbox"/> Other, specify _____ (Skip to Section 9) If yes; actual/verified seat # _____				
Was this person a known close contact of the index case outside of this flight (e.g. family member)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last known exposure to index case: ___/___/___				
When was person interviewed? (check all that apply) <input type="checkbox"/> During first six days after flight? <input type="checkbox"/> During first 21 days after flight? <input type="checkbox"/> After incubation period (max 21 days after flight)?				
5. IMMUNITY				
MMR (or other measles-containing vaccine) or history of disease (select one): <input type="checkbox"/> Not vaccinated <input type="checkbox"/> One dose of vaccine <input type="checkbox"/> Two doses of vaccine <input type="checkbox"/> Three doses of vaccine <input type="checkbox"/> Immunized, number of doses unknown <input type="checkbox"/> History of disease <input type="checkbox"/> Born before 1957 <input type="checkbox"/> Immunity established by serology <input type="checkbox"/> Unknown				
6. MEASLES INTERVENTION RELATED TO EXPOSURE ON THE FLIGHT				
Did contact receive prophylaxis for this exposure to measles? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not (select one)? <input type="checkbox"/> Outside window for prophylaxis <input type="checkbox"/> Within window for prophylaxis but declined <input type="checkbox"/> History of measles prior to flight <input type="checkbox"/> Born before 1957 <input type="checkbox"/> Immune (by vaccination or serology) <input type="checkbox"/> Other, specify: _____ If yes, please indicate what s/he/they received and the date: <input type="checkbox"/> MMR or other measles-containing vaccine; date received: _____ <input type="checkbox"/> Immunoglobulin; date received: ___/___/___				
7. HEALTH SINCE FLIGHT				
Did contact report any signs or symptoms of measles? <input type="checkbox"/> No (Skip to Section 9) <input type="checkbox"/> Yes <input type="checkbox"/> Unknown If yes, check all that apply: <input type="checkbox"/> Fever (Max temp measured _____°C/F) <input type="checkbox"/> Rash <input type="checkbox"/> Cough <input type="checkbox"/> Coryza <input type="checkbox"/> Conjunctivitis Check any of the following potential measles exposures this person may have had in the 21 days prior to symptom onset: <input type="checkbox"/> Visited/lives in a country with endemic measles <input type="checkbox"/> Exposed to a person with a confirmed measles case <u>other than the index case on the flight</u> <input type="checkbox"/> Other, specify: _____				
8. DIAGNOSIS				
Was this person diagnosed with measles? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If unknown, why? <input type="checkbox"/> Declined medical evaluation <input type="checkbox"/> Not interviewed after incubation period (max of 21 days after flight) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Other, specify _____ If yes, how was diagnosis made? (Check all that apply) <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 <input type="checkbox"/> Other, specify: _____				
9. FORM COMPLETION				
Person(s) completing form: _____			Date form completed: ___/___/___	
10. COMMENTS				