MEASLES NOTIFICATION FAX FORM

TO:	Community and Public Health	ATTENTION:	Medical Officer of Health
FAX:	(03) 3768 1169	DATE:	

CAUTION: *The information contained in this facsimile is **legally privileged and confidential**. If you have received this message in error, please forward to the above destination without delay. If the reader of this message is not the intended recipient you are hereby notified that any use, dissemination, distribution or reproduction of this message is prohibited. Failure to comply with this caution could result in legal action. Thank you.*

Case Identification

Name: _____ _____
Surname Given Name

Address: _____ _____
Number Street

_____ _____
Suburb City

Phone:
Home: (___) _____

Work: (___) _____

Cell: (___) _____

Date of Birth: ___ /___ /___

NHI number: _____

Sex: ☐ Male ☐ Female

Ethnicity: (tick all that apply)

☐ NZ Maori ☐ NZ Pakeha/European ☐ Other European

☐ Pacific Islander ☐ Other (specify):

Case Demography

Occupation: _____

Place of Work/School/Preschool: _____

Basis of Diagnosis

Fever 38.0° C	☐ Yes	☐ No	☐ Unknown
Maculopapular Rash (If yes, date of onset ___ / ___ / ___)	☐ Yes	☐ No	☐ Unknown
Cough	☐ Yes	☐ No	☐ Unknown
Coryza	☐ Yes	☐ No	☐ Unknown
Conjuctivitis	☐ Yes	☐ No	☐ Unknown
Koplik's Spots	☐ Yes	☐ No	☐ Unknown

Laboratory confirmation of disease: ☐ Yes ☐ No ☐ Not Done ☐ Awaiting Results
Confirmation Method Nasopharyngeal Swab PCR ☐ Serology ☐ Date Done ___ / ___ / ___
Medical Laboratory Used: ☐ *Cardinal* ☐ *Canterbury Health* ☐ *Medlab South* ☐ *Southern Community*

MMR Immunisation Status

First Dose Administered: ☐ MMR/Monovalent ☐ Unknown

Date Given Or age when first dose given _____ ☐ Weeks ☐ Months ☐ Years

Source of Information ☐ Patient/Caregiver recall ☐ Documented

Second Dose Administered: ☐ MMR/Monovalent ☐ Unknown

Date Given Or age when second dose given _____ ☐ Weeks ☐ Months ☐ Years

Source of Information ☐ Patient/Caregiver recall ☐ Documented

Notifier Identification

Doctor's Name: _____ Contact Phone: (__)_____ Fax : (__) _____

Surgery Name:_____