

Suspect Measles Provider Evaluation Worksheet

Suspected and confirmed measles cases are IMMEDIATELY reportable to your Local Health Jurisdiction

Patient Information:	Name:		DOB:		MRN #:
Address:		City:	County:	State:	Zip:
Evaluation date:		(If patient is a minor) Parent/Guardian Name:		Phone #: (____) ____-____	
Reporting Facility:		Clinician name:		Clinician phone #: (____) ____-____	
Consider measles in the differential diagnosis of patients with FEVER and RASH:					
A) What is the highest temperature recorded?		°F	Fever onset date: ____ / ____ / ____ <input type="checkbox"/> N/A (afebrile)		
B) Does the patient have a rash?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no rash, do not collect measles specimens. Consider rule-out testing for other causes of febrile rash illness.	
C) Rash characteristics:		Rash onset date: ____ / ____ / ____			
<ul style="list-style-type: none"> Was rash preceded by one of the symptoms listed in (D) by 2-4 days? Did fever overlap rash? Did rash start on head or face? 		<input type="checkbox"/>	<input type="checkbox"/>	Measles rash is generally red, maculopapular (no vesicles) and may become confluent. It typically starts at the hairline, then progresses down the face and body. Rash onset typically occurs 2-4 days after symptom onset, which includes fever and at least one of the "3 Cs" (below).	
D) Has the patient had any of the following symptoms?		Additional symptom notes:			
<ul style="list-style-type: none"> Cough Runny nose (coryza) Red eyes (conjunctivitis) 		<input type="checkbox"/>	<input type="checkbox"/>	Onset date: ____ / ____ / ____	
E) Known high-risk exposure in past 21 days? (ex. Exposure to a confirmed case, international travel, or domestic travel to an area with a current outbreak)		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Date(s) and place(s) of travel or exposure:	
F) What is the patient's measles immunity status?		<input type="checkbox"/> Born before Jan 1, 1957 (Presumed immunity) <input type="checkbox"/> Unknown <input type="checkbox"/> At least one documented measles vaccine. Vaccine date(s): 1st Dose: ____ / ____ / ____ 2nd Dose: ____ / ____ / ____ <input type="checkbox"/> Unvaccinated (0 doses measles vaccine)			

Fever (A) + a "YES" answer in (B), at least ONE "YES" in (C) and (D), + "YES" in (E) = Measles is HIGHLY SUSPECTED.

IF MEASLES IS SUSPECTED, IMMEDIATELY:

- Mask and isolate the patient (in negative air pressure room when possible).
- Call your **LOCAL HEALTH JURISDICTION** to report the suspected measles case and request permission to test at **WA PHL**. (All health care providers must receive approval from local health jurisdiction prior to specimen submission.)
Local Health Jurisdiction: _____ 24/7 contact number: _____
- Collect the following specimens, if testing is approved:
 - (Preferred specimen) **Nasopharyngeal (NP) OR Oropharyngeal (OP) swab for measles PCR and culture**
 - Most accurate between 0 to 5 days after rash onset.
 - Urine for measles PCR and culture:**
 - Most accurate between 3 to 10 days after rash onset; may not be positive until >4 days after symptom onset.
 - ☐ (Acceptable) **Serum for measles IgM and IgG testing:**
 - IgM is most accurate greater than 3 days after rash onset
 - NOTE:** neither IgM nor IgG antibody responses can distinguish measles disease from the response to vaccination in a patient with suspected measles that has been vaccinated 6–45 days prior to blood collection.

For more information on measles specimen collection, testing, reporting, and other details, please visit:

[WA DOH PHL Measles Specimen Collection and Submission Instructions](#)

[WA Department of Health Measles Provider Resource webpage.](#)