IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

IBL SUPPLEMENTARY FORM FOR MEASLES

Submit this supplementary form when requesting measles testing at the Idaho Bureau of Laboratories. Please contact your local Public Health Dept. and review guidance for measles testing before submitting specimens. **Results will be shared with your local public health district, which may contact the healthcare provider for more information.**

Date Submitted: _______________ **Ordering Provider Name**____
Ordering Provider Phone Number____

PATIENT

Last name: ____________________________**First name**:_____________________________**DOB**: ___________

County of residence: _____________________________

EPIDEMIOLOGY

Date of rash onset: ____________
Did rash start on head or face? No Yes
Maculopapular rash? No Yes
Did fever overlap rash? No Yes No fever
Was rash preceded (by 2 to 4 days) by at least one of:
cough, runny nose, or red eyes? No Yes

First symptom onset: *(check all)*:
☐ **Fever, Date:** ______________
Highest Recorded Temp _______°F
Cough, Date: _______________
Runny nose (coryza), Date: _______________
Red eyes (conjunctivitis), Date: ____________

Was the patient hospitalized due to this illness? ☐ Unk ☐ No ☐ Yes

Is patient immunized for measles? ☐ Unk ☐ No ☐ Yes
Dates of measles vaccine doses (if known): #1 ________________ #2 ________________ #3________________

EXPOSURE HISTORY

Did the patient have known high risk exposure during the exposure period (7–21 days prior to rash onset)?
☐ Unk ☐ No ☐ Yes, detail: ☐ Confirmed measles case ☐ Travel ☐ Healthcare Visit ☐ Identified public venue
Date of first exposure: _______________ Date of last exposure: _______________
Details:

Did the patient receive immune globulin as post-exposure prophylaxis (PEP)?
☐ Unk ☐ No ☐ Yes, date of IG: _______________
Did the patient receive MMR as PEP? ☐ Unk ☐ No ☐ Yes, date of MMR: _______________

SPECIMEN

For specimens inbound to IBL:
Which specimens were collected? ☐ NP ☐ Serum ☐ Urine
When were specimens collected? _______________ _______________ _______________
Shipping: ☐ FedEx ☐ UPS ☐ Courier ☐ PHD Staff ☐ Other _____________________
Tracking number, if known: ____
Date of expected arrival at IBL: _______________

Please note: In addition, an IBL Clinical Test Request Form must accompany each specimen sent to IBL.
http://healthandwelfare.idaho.gov/Portals/0/Health/Labs/Clinical_Test_Request_Form.pdf

LAB RESULTS

Commercial Lab Results

Test	**Result**	**Date**
Measles IgM	☐ Pos ☐ Neg ☐ Equiv ☐ Not done ☐ Pending	________________
Measles IgG	☐ Pos ☐ Neg ☐ Equiv ☐ Not done ☐ Pending	________________

NOTES

Notes:

Idaho Bureau of Laboratories • 2220 Old Penitentiary Road • Boise, ID 83712
Visit www.statelab.idaho.gov for Sampling and Submission Guides and Client Billing Form.
Phone: 208-334-2235
Fax: 208-334-4067