NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services & Trauma Systems

Measles EMS Contact Form

Name of Agency:		Agency Code:	
Incident County:		Incident City:	
Incident Zip Code:		Patient Age:	

Y	N	U	Patient History
			Recent Travel
			Contact with International Travelers
			Contact with Measles Infected Persons
			Measles Vaccination or Immunity

Y	N	U	Onset Date	Patient Symptoms
				Fever
				Cough
				Malaise
				Rash
				Runny Nose
				Red, Watery Eyes
				Koplik Spots

Transport Information	
Destination Hospital:	
Pre-notification made to: *(Provide name of person notification was given to)*	

Provider Information			
EMT Number:		EMT Number:	
EMT Number:		EMT Number:	
Other Agency/Dept. Present:			
Name of Person Completing Form:			

Instructions:

Complete this form for any suspected measles related ambulance transport and fax to the NYS Bureau of EMS at (518) 402-0985.