

Congenital Rubella Syndrome(CRS)

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control
 Infectious Disease Epidemiology Program
 Phone: 304-558-5358 or 800-423-1271 in West Virginia
 Fax: 304-558-8736

Investigation Information

* indicates required fields

Investigation Status*

Closed Open Regional Review State Review Superseded Unassigned

Case Status*

Confirmed Not a Case Probable Suspect Unknown

Patient Information

* indicates required fields

Last Name*

First Name*

Middle Initial

Street Address

City

County

State

West Virginia

Zip

Is the patient's residence a:

Correctional Facility (Specify) _____ Long Term Care Facility (Specify) _____
 Shelter or Group Home (Specify) _____ None of the above

Home Phone

###-###-####

Ext.

Other Phone

###-###-####

Ext.

Report Date

mm/dd/yyyy

Parent / Guardian Information

Last Name

First Name

Middle Initial

Relationship to Patient

Check if address is same as above; otherwise complete guardian contact information below

Guardian Street Address

City

County

State

West Virginia

Zip

Home Phone

###-###-####

Ext.

Other Phone

###-###-####

Ext.

Patient Demographic Information

* indicates required fields

Sex

Male Female Transsexual Unknown Failure to report sex/missing sex Other (Specify) _____

Date of Birth*

mm/dd/yyyy

Age

Age Units

Days Weeks Months Years

Patient Demographic Information cont.

Ethnicity
 Hispanic or Latino *Not Hispanic or Latino* *Unknown* *Failure to report ethnicity/missing ethnicity*

Race
 (Check all that apply)
 American Indian or Alaska Native *Asian*
 Black or African American *Native Hawaiian or Other Pacific Islander* _____
 White *Unknown*
 Failure to report race/missing race *Some Other Race* _____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy	Age Congenital Rubella Syndrome Diagnosed (Check all that apply) <input type="checkbox"/> <i>Years</i> <input type="checkbox"/> <i>Months</i> <input type="checkbox"/> <i>< 1 Month</i> <input type="checkbox"/> <i>Unknown</i>	Date of diagnosis mm/dd/yyyy
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Did patient die, date of death

Is Child Living <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	If No, Date of Death mm/dd/yyyy	If Child Died, Was Autopsy Performed? <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Final Anatomical Diagnosis
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Birth Weight
 (Check all that apply)
 Grams (specify) _____ *lbs (specify)* _____ *oz. (specify)* _____ *Unk.*

Gestational Age: (weeks)	Causes of Death (from death certificate)
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Cataracts <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Hearing Loss <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Mental Retardation <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Meningoencephalitis <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>
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Microencephaly <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Purpura <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Enlarged Spleen <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Enlarged Liver <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>
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Congenital Glaucoma <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Pigmentary Retinopathy <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Long Bone Radiolucencies <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>
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Congenital Heart Disease

Patent Ductus Arteriosus <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Peripheral Pulmonic Stenosis <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>	Congenital Heart Disease Type Unknown <input type="radio"/> <i>Yes</i> <input type="radio"/> <i>No</i> <input type="radio"/> <i>Unknown</i>
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Other, Specify

Clinical Diagnosis <input type="radio"/> <i>Infection Only</i> <input type="radio"/> <i>Still Birth</i>

Laboratory Information

Clinical Characteristics

Specimen for Viral Study <input type="radio"/> No <input type="radio"/> Yes	Did Mother Have Serologic Testing For Rubella Immunity Prior To Exposure <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Interpretation of Test Result <input type="radio"/> Susceptible <input type="radio"/> Immune <input type="radio"/> Unknown
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Lab Results						
Mother or Infant	Type Specimen	Date Collected	Laboratory	Specific Method Used	If Other Method, Specify	Test Results
M=Mother I=Infant		mm/dd/yyyy		VC=Viral Cultures EL=ELISA RIA=RIA HAI=Hemagglutination Inhibition IFA=IFA LA=Latex Agglutination PHIA=Passive Hemagglutination OTH=Other		

****If Antibody Testing Was Performed, Please Specify Which Rubella-Specific Immunoglobulin Antibody (IgM or IgG) Was Used**

Laboratory Name	Phone ###-###-####	Ext.	Fax Number ###-###-####
Address		State: West Virginia	Zip:

Reporting Source

Last Name	First Name	Phone ###-###-####	Ext.	Fax ###-###-####
Facility				
Address		State West Virginia	Zip	E-mail

Provider with Further Patient Information			
Last Name	First Name	Phone ###-###-###	Ext.
Address	City	State West Virginia	Fax ###-###-###
			Zip

Public Health Investigation

Name of Person Interviewed		Relationship to Patient		Date reported to public health mm/dd/yyyy	
Investigator		Date public health investigation began mm/dd/yyyy		Health Department	
Ext.		Phone ###-###-####			
Investigation ID		Part of an Outbreak? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Outbreak Name	
Date First Reported to a Health Department mm/dd/yyyy		Date Case Investigation Started mm/dd/yyyy			
		Lost to follow-up? <input type="radio"/> Yes <input type="radio"/> No			

Maternal History

Mother's Information							
Last Name		First Name		Middle Initial		Age at Delivery	
Occupation at Time of Conception <input type="radio"/> Occupation <input type="radio"/> Unemployed <input type="radio"/> Unknown							
Did Mother Attend Family Planning Clinic Prior to Conception <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				Number of Previous Live Births <input type="radio"/> No. <input type="radio"/> Unknown		Number of Previous Pregnancies <input type="radio"/> No. <input type="radio"/> Unknown	
Prenatal Care For This Pregnancy <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			Date of 1st Visit mm/dd/yyyy		Was Prenatal Care Obtained in <input type="radio"/> Public Sector <input type="radio"/> Private Sector <input type="radio"/> Unknown		
Rubella-Like Illness During Pregnancy <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			If Yes, Month of Pregnancy			Check if month of pregnancy is unknown. <input type="checkbox"/> Unknown	
Was Rubella Diagnosed by a Physician at Time of Illness <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					If not MD, by Whom		
Was Rubella Serologically Confirmed at Time of Illness <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown							
Location of Exposure Within U.S. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				Location of Exposure Outside U.S. <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
If Yes, Specify Country (If Known, Specify City/County)							
If Location of Exposure is Unknown, Did Mother Travel Outside the U.S. During the 1st Trimester of Pregnancy <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			If Yes, Specify Country (If Known, Specify City/County)			Date of Travel mm/dd/yyyy	
Date Traveled <input type="checkbox"/> Unknown							
Was the Mother Directly Exposed to a Known Rubella Case <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			If Yes, Please Specify Relationship		Date of Exposure mm/dd/yyyy		Date Exposed <input type="checkbox"/> Unknown
Number of Other Children < 18 yrs. Living in Household During This Pregnancy				Were Any of the Children Immunized With Rubella Vaccine <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			

