

Rubella (German Measles)

PATIENT DEMOGRAPHICS

| | |
|--|--|
| Name (last, first): _____ | *Birth date: __/__/____ Age: _____ |
| Address: _____ | *Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk |
| City/State/Zip: _____ | *Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk |
| Phone (home): _____ Phone (work) : _____ | *Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. (Mark all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Unk |
| Occupation/grade: _____ Employer/School: _____ | |
| Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____ | |

INVESTIGATION SUMMARY

| | |
|---|--|
| Local Health Department (Jurisdiction): _____ | Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk |
| Investigator : _____ | WVEDSS ID: _____ |
| Investigator phone: _____ | Case Classification: |
| Investigation Start Date: __/__/____ | <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown |

REPORTING SOURCE

| | |
|--|--|
| *Date of report: __/__/____ | Report Source: <input type="checkbox"/> Laboratory <input type="checkbox"/> Hospital <input type="checkbox"/> Physician <input type="checkbox"/> Public Health Agency <input type="checkbox"/> Other |
| Report Source Name: _____ | Address: _____ Phone: _____ |
| Earliest date reported to county: __/__/____ | Earliest date reported to state: __/__/____ |
| Reporter Name: _____ | Address: _____ Phone: _____ |

CLINICAL

| | |
|--------------------------|----------------------------|
| Physician Name: _____ | Physician Facility : _____ |
| Physician Address: _____ | Phone Number: _____ |

Hospital

*Was patient hospitalized for this illness? Y N U
If yes: Hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____

Condition Diagnosis date: __/__/____ *Illness onset date: __/__/____ Illness end date: __/__/____

Did/does patient have:

Y N U
 Maculopapular rash If yes: Rash onset date: __/__/____ Rash duration (in days): _____
 Fever
 Highest measured temperature: _____° Fahrenheit Celsius

Symptoms

Y N U
 Arthralgia/Arthritis
 Lymphadenopathy
 Conjunctivitis

Complications

Y N U
 Arthralgia/Arthritis
 Encephalitis
 Thrombocytopenia
 Other complications (specify): _____

Did patient die from rubella or complications (including secondary infection) associated with rubella? Y N U
If yes, cause of death: _____

Clinical notes

*LABORATORY (Please submit copies of all labs to DIDE)

Y N U
 Was laboratory testing done for rubella?
 Were clinical specimens sent to CDC for genotyping? If yes: Date sent for genotyping: __/__/____
 Specimen type: Blood CSF Nasopharyngeal Throat Urine Other (specify): _____
 Was the rubella virus genotype sequenced?
 If yes, genotype: 1a 1B 1C 1D 1E 1g 2A 2B 2c Unknown Other (specify): _____

LABORATORY TESTING

| *Type of test | Date of collection | Source of specimen | Result value | Result | Lab |
|------------------------|--------------------|--------------------|--------------|--------|-----|
| IgM (1 st) | | | | | |
| IgM (2 nd) | | | | | |
| IgG | | | | | |
| IgG – Acute | | | | | |
| IgG – Convalescent | | | | | |
| Viral Isolation | | | | | |
| PCR | | | | | |
| Other (specify) | | | | | |
| Other (specify) | | | | | |
| Other (specify) | | | | | |

Lab notes**VACCINE INFORMATION**

Did the patient receive a rubella-containing vaccine? Y N U If yes: Number of doses ON or AFTER first birthday? ____
 If not vaccinated, what was the reason?

Lab evidence of previous disease MD diagnosis of previous disease Medical contraindication Parental Refusal
 Philosophical objection Religious exemption Under age for vaccination Unknown Other (specify) _____

***VACCINATION RECORD**

| | |
|--|---|
| Date received: __/__/____ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/____ | Given by: Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____ |
| Date received: __/__/____ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/____ | Given by: Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____ |
| Date received: __/__/____ Anatomical site: _____ Vaccine administered: _____ Vaccine ID: _____ Manufacturer: _____ Organization ID: _____ Lot #: _____ Expiration Date: __/__/____ | Given by: Last Name: _____ First Name: _____ Provider ID: _____ Organization Name: _____ Organization ID: _____ |

EPIDEMIOLOGIC

Y N U
 *Is this case epi-linked to a laboratory-confirmed case? If yes, case ID of epi-linked case: _____
 *Transmission Setting (where did this case acquire pertussis?):
 Athletics College Community Correctional facility
 Daycare Doctor's office Home Hospital ER
 Hospital outpatient clinic Hospital ward International travel Military
 Place of worship School Work Other Unknown

Y N U
 * Is this case part of an outbreak of 3 or more cases? If yes, name of outbreak? _____
 Source of infection (i.e. Person ID, place, etc.): _____
 Did rash onset occur 14-23 days upon entering the USA, following any travel or living outside the USA?
 *Is this case traceable (linked) to an international import?
 *Is this case epi-linked to another confirmed or probable case?
 Were age and setting verified?

Where was the disease acquired?
 Indigenous, within jurisdiction Out of country Out of jurisdiction, from another jurisdiction Out of state Unknown

Confirmation method:
 Active surveillance Case/Outbreak management Clinical diagnosis (not lab confirmed) Epidemiologically linked
 Lab confirmed Lab report Local/State specified Medical record review
 No information given Occupational disease Provider certified Other (specify): _____
 surveillance

MEDICAL HISTORY

Length of time in the US (in years)? _____ Country of birth? _____

*If this is a female, is she pregnant? Y N U If yes, what is the expected delivery date? __/__/__

Expected place of delivery: _____ Number of weeks gestation at time of disease? _____

Trimester of gestation at time of disease? First Second Third Unknown

Note: Please follow-up on this case 2 weeks prior to delivery date to determine whether or not the baby has Congenital Rubella Syndrome (CRS) or Congenital Rubella Infection (CRI).

Is there documentation of previous rubella immunity testing? Y N U

If yes, result: Indeterminate Negative Positive Pending Unknown Not Done

Year of immunity testing: _____ Age of woman at time of immunity testing (in years): _____

Did the woman ever have rubella disease prior to this pregnancy? Y N U

If yes, was previous rubella disease serologically confirmed by a physician? Y N U

Year of previous disease: _____ Age of woman at time previous disease (in years): _____

What was the outcome of the current pregnancy? Live birth Not a live birth Unknown Other

If a live birth: Live birth with CRS Live birth with infection only Live birth without CRS or infection

If not a live birth: Elective termination Fetal death Spontaneous abortion Stillbirth

At the time of cessation of pregnancy, what was the age of the fetus (in weeks)? _____

Was autopsy/pathology study conducted? Y N U

If yes, result of autopsy/pathology study: _____

PUBLIC HEALTH ACTIONS/NOTES

Public health action (education, prevention, intervention, etc.) done. If yes, specify date __/__/__

Lost to follow-up

