

**North Carolina Department of Health and Human Services  
Division of Public Health • Epidemiology Section  
Communicable Disease Branch**



**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department  
Communicable Disease Control  
414 East Main Street  
Durham, NC 27701

Telephone: (919) 560-7600  
Fax: (919) 560-7716

**RUBELLA**

**Confidential Communicable Disease Report—Part 2  
NC DISEASE CODE: 36**

**REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.**

|                     |       |        |        |              |       |                               |
|---------------------|-------|--------|--------|--------------|-------|-------------------------------|
| Patient's Last Name | First | Middle | Suffix | Maiden/Other | Alias | Birthdate (mm/dd/yyyy)<br>/ / |
|                     |       |        |        |              |       | SSN                           |

|   |                            |  |   |  |  |  |
|---|----------------------------|--|---|--|--|--|
|   | <b>NC EDSS LAB RESULTS</b> | Verify if lab results for this event are in NC EDSS. If not present, enter results.  |   |  |  |  |
| Was testing for rubella or measles done?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                            |  | Please specify disease<br><input type="checkbox"/> Measles <input type="checkbox"/> Rubella |  |  |  |
| Date IgM specimen taken<br>Month Day Year   |                            | IgM result<br><input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done<br><input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Unknown                                  |   |  |  |  |
| Date IgG acute specimen taken<br>Month Day Year   |                            | IgG result<br><input type="checkbox"/> Significant rise in IgG <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done<br><input type="checkbox"/> No significant rise in IgG <input type="checkbox"/> Pending <input type="checkbox"/> Unknown |   |  |  |  |
| Date IgG convalescent specimen taken<br>Month Day Year  |                            | Specify other lab method   |   | Other results<br><input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Not done<br><input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Unknown |  |  |

|  |   |  |  |  |  |   |  |  |
|--|---|--|--|--|--|---|--|--|
|  | <b>NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE</b> |  |  |  |  |   |  |  |
| Is/was patient symptomatic for this disease? ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>If yes, symptom onset date (mm/dd/yyyy): _/ _/ _<br>CHECK ALL THAT APPLY:<br>Fever ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br><input type="checkbox"/> Yes, subjective <input type="checkbox"/> No<br><input type="checkbox"/> Yes, measured <input type="checkbox"/> Unknown<br>Highest measured temperature _____<br>Fever onset date (mm/dd/yyyy): _____<br>Skin rash ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Onset date (mm/dd/yyyy): _____<br>Anatomic site rash began:<br><input type="checkbox"/> Head<br><input type="checkbox"/> Trunk<br><input type="checkbox"/> Upper extremities<br><input type="checkbox"/> Lower extremities<br>Observed by health care provider ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Duration of rash: _____<br>Unit: <input type="checkbox"/> Hours <input type="checkbox"/> Days <input type="checkbox"/> Weeks<br>Location:<br><input type="checkbox"/> All over the body (generalized)<br><input type="checkbox"/> Generalized, predominately central/torso/back (centripetal)<br><input type="checkbox"/> Generalized, predominately face/hands/feet (centrifugal)<br><input type="checkbox"/> Localized/Focal<br><input type="checkbox"/> Palms and soles<br><input type="checkbox"/> Unknown<br>Appearance of rash (choose all that apply):<br><input type="checkbox"/> Macular Papular <input type="checkbox"/> Pustular <input type="checkbox"/> Unknown<br><input type="checkbox"/> Petechial <input type="checkbox"/> Bullous <input type="checkbox"/> Vesicular |   |  | Skin itching (pruritis) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Conjunctivitis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Runny nose and/or teary eyes (coryza) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Thrombocytopenia ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Encephalitis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Joint pains (arthralgias) ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Arthralgia/arthritis ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Lymphadenopathy ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Other symptoms, signs, clinical findings, or complications consistent with this illness? ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>If yes, specify: _____<br><b>PREGNANCY</b><br>Is the patient currently pregnant? ... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Estimated delivery date (mm/dd/yyyy): _____<br>Give number of weeks gestation at onset of illness: _____<br>Has the mother received prenatal care? ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Prenatal provider name _____<br>OB Name _____<br>Street address _____<br>City _____<br>State _____<br>Zip code _____<br>Phone (_____) _____ |  |  | Does the patient have prior evidence of serological immunity to rubella? ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Test date (mm/dd/yyyy): _____<br>Result:<br><input type="checkbox"/> Positive<br><input type="checkbox"/> Negative<br><input type="checkbox"/> Equivocal<br><input type="checkbox"/> Unknown<br>Was previous rubella disease confirmed serologically? ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Date of disease (mm/dd/yyyy): _____<br><b>MATERNAL INFORMATION</b><br>Please complete if the child is 12 months of age or younger:<br>Was the biologic mother born outside the US? ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>If yes, country: _____<br>Date of biologic mother's arrival in the US (mm/dd/yyyy): _____<br>Did the biologic mother ever have evidence of serological IgG immunity? ..... <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U<br>Test date (mm/dd/yyyy): _____<br>Result:<br><input type="checkbox"/> Positive<br><input type="checkbox"/> Negative<br><input type="checkbox"/> Equivocal<br><input type="checkbox"/> Unknown |  |  |

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|                     |       |        |        |              |       |                        |
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**NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE (CONTINUED)**

**Was the child's biologic mother immunized with vaccine against this specific disease?**  Y  N  U

If yes, type of vaccine:  
 Vaccine #1:  
 Date of vaccination (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Vaccine type: \_\_\_\_\_  
 Manufacturer: \_\_\_\_\_  
 Product/trade name: \_\_\_\_\_  
 Lot number: \_\_\_\_\_  
 Vaccine #2:  
 Date of vaccination (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Vaccine type: \_\_\_\_\_  
 Manufacturer: \_\_\_\_\_  
 Product/trade name: \_\_\_\_\_  
 Lot number: \_\_\_\_\_

**Reason for inadequate vaccination:**

Religious exemption  
 Medical exemption  
 Medical contraindication  
 Philosophical exemption (outside NC only)  
 Laboratory evidence of previous disease  
 Physician diagnosis of previous disease  
 Under age for vaccination  
 Parental refusal  
 Missed opportunities  
 Unknown  
 Other, specify: \_\_\_\_\_

**Source of vaccine information:**

Patient's or Parent's verbal report  
 Physician  
 Medical record  
 Certificate of immunization record  
 Patient vaccine record  
 School record  
 Other, specify: \_\_\_\_\_  
 NCIR record  
 Unknown

**Was patient hospitalized for this illness >24 hours?**  Y  N  U

Hospital name: \_\_\_\_\_  
 City, State: \_\_\_\_\_  
 Hospital contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Admit date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Discharge date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

**Does the patient know anyone else with similar symptoms?**  Y  N  U

If yes, specify name and relationship to person: \_\_\_\_\_

**Is the patient part of an outbreak of this disease?**  Y  N

**VACCINE**

**Has patient/contact ever received rubella-containing vaccine?**  Y  N  U

**If yes, date of vaccination #1**  
 (mm/dd/yyyy) \_\_\_\_\_  
 Vaccine type: \_\_\_\_\_  
 Manufacturer: \_\_\_\_\_  
 Product/trade name: \_\_\_\_\_  
 Lot number: \_\_\_\_\_

**If yes, date of vaccination #2**(mm/dd/yyyy) \_\_\_\_\_  
 Vaccine type: \_\_\_\_\_

Manufacturer: \_\_\_\_\_  
 Product/trade name: \_\_\_\_\_  
 Lot number: \_\_\_\_\_  
 Vaccine date unknown .....  Y  N

**If no, reason for inadequate vaccination:**

Religious exemption  
 Medical exemption  
 Medical contraindication  
 Philosophical exemption (outside NC only)  
 Laboratory evidence of previous disease  
 Physician diagnosis of previous disease  
 Under age for vaccination  
 Parental refusal  
 Missed opportunities  
 Unknown  
 Other, specify: \_\_\_\_\_

**Source of vaccine information:**

Patient's or Parent's verbal report  
 Physician  
 Medical record  
 Certificate of immunization record  
 Patient vaccine record  
 School record  
 Other, specify: \_\_\_\_\_  
 NCIR record  
 Unknown

**If yes, number of doses received on or after first birthday:** \_\_\_\_\_

**PREDISPOSING CONDITIONS**

**Any immunosuppressive conditions?**  Y  N  U

Specify \_\_\_\_\_

**Autoimmune disease** .....  Y  N  U

Specify \_\_\_\_\_

**Other underlying illness** .....  Y  N  U

Please specify: \_\_\_\_\_

**Was the patient receiving any of the following treatments or taking any medications?**

Antibiotics .....  Y  N  U  
 For what medical condition? \_\_\_\_\_

Chemotherapy .....  Y  N  U  
 If yes, was therapy within the last 30 days before this illness? .....  Y  N  U  
 For what medical condition? \_\_\_\_\_

Radiotherapy .....  Y  N  U  
 If yes, was therapy within the last 30 days before this illness? .....  Y  N  U  
 For what medical condition? \_\_\_\_\_

Systemic steroids/corticosteroids, including steroids taken by mouth or injection .....  Y  N  U  
 If yes, was medication taken within the last 30 days before this illness? .....  Y  N  U  
 For what medical condition? \_\_\_\_\_

Immunosuppressive therapy, including anti-rejection therapy .....  Y  N  U

If yes, specify: \_\_\_\_\_  
 If yes, was medication taken within the last 30 days before this illness? .....  Y  N  U  
 For what medical condition? \_\_\_\_\_

Aspirin or aspirin-containing product ...  Y  N  U  
 If yes, was medication taken within the last 30 days before this illness? .....  Y  N  U  
 For what medical condition? \_\_\_\_\_

**REASON FOR TESTING**

**Why was the patient tested for this condition?**

Symptomatic of disease  
 Screening of asymptomatic person with reported risk factor(s)  
 Exposed to organism causing this disease (asymptomatic)  
 Household / close contact to a person reported with this disease  
 Other, specify \_\_\_\_\_  
 Unknown

**CLINICAL OUTCOMES**

**Discharge/Final diagnosis:** \_\_\_\_\_

Survived? .....  Y  N  U  
 Died? .....  Y  N  U  
 Died from this illness? .....  Y  N  U  
 Patient died in North Carolina? .....  Y  N  U  
 County of death: \_\_\_\_\_  
 Died outside NC? .....  Y  N  U  
 Specify where: \_\_\_\_\_  
 Autopsy performed? .....  Y  N  U  
 Facility where autopsy was performed: \_\_\_\_\_

Patient autopsied in NC? .....  Y  N  U  
 County of autopsy: \_\_\_\_\_  
 Autopsied outside NC, specify where: \_\_\_\_\_

Source of death information (select all that apply):  
*Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.*

Death certificate  
 Autopsy report final conclusions  
 Hospital/physician discharge summary  
 Other: \_\_\_\_\_

Cause of death: \_\_\_\_\_  
 Death date (mm/dd/yyyy): \_\_\_\_\_

**TREATMENT**

**Did patient take an antibiotic as treatment for this illness?** .....  Y  N  U

If yes, specify antibiotic name: \_\_\_\_\_  
 Dose \_\_\_\_\_  
 Date antibiotic began (mm/dd/yyyy): \_\_\_\_\_  
 Date antibiotic ended (mm/dd/yyyy): \_\_\_\_\_

**Did the patient receive medical care for this illness?** .....  Y  N  U

Specify level(s) of care (check all that apply):

Outpatient  
 Emergency department  
 Inpatient  
 Other  
 Unknown

|                     |       |        |        |              |       |                        |
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|                     |       |        |        |              |       | SSN                    |

**TRAVEL/IMMIGRATION**

**The patient is:**

Resident North Carolina

Resident of another state or US territory

Foreign visitor

Refugee

Refugee camp(s)? .....  Y  N  U

Name of camp \_\_\_\_\_

Location of camp \_\_\_\_\_

Country of birth \_\_\_\_\_

Last country prior to arrival in US \_\_\_\_\_

Date of entry to US \_\_\_\_\_

Recent immigrant

Country of birth \_\_\_\_\_

Last country prior to arrival in US \_\_\_\_\_

Date of entry to US \_\_\_\_\_

Foreign adoptee

Country of birth \_\_\_\_\_

Last country prior to arrival in US \_\_\_\_\_

Date of entry to US \_\_\_\_\_

None of the above

**Did patient have a travel history during the 7 days prior to onset of symptoms until 4 days after rash onset?** .....  Y  N  U

Travel dates: From: \_\_\_\_\_ until \_\_\_\_\_

To city: \_\_\_\_\_ State: \_\_\_\_\_

To country: \_\_\_\_\_

Reason(s) for travel:

Vacation / tourism       Airline / Ship crew

Organized tour             Missionary or dependent

Business related, specify \_\_\_\_\_

Military related             Refugee / Immigrant

Visit to family / friends    Student / Teacher

Peace corps                  Unknown

Other \_\_\_\_\_

Mode(s) of transportation (check all that apply)

Airplane

Ship / boat / ferry

Cruise ship? .....  Y  N  U

Specify cruise line \_\_\_\_\_

Train / subway

On foot

Bus/taxi/shuttle

Automobile / motorcycle

Other, specify: \_\_\_\_\_

**Was patient pregnant while traveling?** .....  Y  N  U

If yes, was travel during the first trimester of pregnancy? .....  Y  N  U

**Does patient know anyone else with similar symptom(s) who had the same or similar travel history?** .....  Y  N  U

Name: \_\_\_\_\_

**Did patient have contact with a person with travel history during the period of interest?** .....  Y  N  U

Contact's name: \_\_\_\_\_

Travel dates: From: \_\_\_\_\_ until \_\_\_\_\_

To city: \_\_\_\_\_

To state: \_\_\_\_\_

To country: \_\_\_\_\_

Is contact a:

Resident of another state or US territory

Foreign visitor

Recent immigrant

Refugee

Foreign adoptee

Unknown

Other, specify: \_\_\_\_\_

**Notes:**

**CHILD CARE/SCHOOL/COLLEGE**

**Patient in child care?** .....  Y  N  U

Name of care provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Patient a child care worker or volunteer in child care?** .....  Y  N  U

Name of child care provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Patient a parent or primary caregiver of a child in child care?** .....  Y  N  U

Name of child care provider: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Is patient a student?** .....  Y  N  U

Type of school:

NC Public School (preK-12)

NC Private School (preK-12)

Other School (preK-12)

Community College/College/University

Other academic institution (i.e. trade school, professional school, etc)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Specify grade: \_\_\_\_\_

**Is patient a school WORKER / VOLUNTEER in NC school setting?** .....  Y  N  U

Type of school

NC Public School (preK-12)

NC Private School (preK-12)

Other School (preK-12)

Community College/College/University

Other academic institution (i.e. trade school, professional school, etc)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

**Notes:**

**BEHAVIORAL RISK & CONGREGATE LIVING**

**During the 7 days prior to onset of symptoms until 4 days after rash onset did the patient live in any congregate living facilities** (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? .....  Y  N  U

Name of facility: \_\_\_\_\_

Dates of contact: \_\_\_\_\_

**During the 7 days prior to onset of symptoms until 4 days after rash onset, did the patient attend social gatherings or crowded settings?** .....  Y  N  U

If yes, specify: \_\_\_\_\_

**In what setting was the patient most likely exposed?**

|   |  |
|---|--|
| <input type="checkbox"/> Restaurant                         | <input type="checkbox"/> Place of Worship                          |
| <input type="checkbox"/> Home                               | <input type="checkbox"/> Outdoors, including woods or wilderness   |
| <input type="checkbox"/> Work                               | <input type="checkbox"/> Athletics                                 |
| <input type="checkbox"/> Child Care                         | <input type="checkbox"/> Farm                                      |
| <input type="checkbox"/> School                             | <input type="checkbox"/> Pool or spa                               |
| <input type="checkbox"/> University/College                 | <input type="checkbox"/> Pond, lake, river or other body of water  |
| <input type="checkbox"/> Camp                               | <input type="checkbox"/> Hotel / motel                             |
| <input type="checkbox"/> Doctor's office/ Outpatient clinic | <input type="checkbox"/> Social gathering, other than listed above |
| <input type="checkbox"/> Hospital In-patient                | <input type="checkbox"/> Travel conveyance (airplane, ship, etc.)  |
| <input type="checkbox"/> Hospital Emergency Department      | <input type="checkbox"/> International                             |
| <input type="checkbox"/> Laboratory                         | <input type="checkbox"/> Community                                 |
| <input type="checkbox"/> Long-term care facility /Rest Home | <input type="checkbox"/> Other (specify) _____                     |
| <input type="checkbox"/> Military                           | <input type="checkbox"/> Unknown                                   |
| <input type="checkbox"/> Prison/Jail/ Detention Center      |  |

**Does the patient have any other risk factors for this disease?** .....  Y  N  U

Specify: \_\_\_\_\_

**ISOLATION/QUARANTINE/CONTROL MEASURES**

**Restrictions to movement or freedom of action?** .....  Y  N

Check all that apply:

Work                             Sexual behavior

Child care                     Blood and body fluid

School                          Other, specify \_\_\_\_\_

Date control measures issued: \_\_\_\_\_

Date control measures ended: \_\_\_\_\_

Was patient compliant with control measures? .....  Y  N

**Did local health director or designee implement additional control measures?** (example: cohort classrooms, special cleaning, active surveillance, etc.) .....  Y  N

If yes, specify: \_\_\_\_\_

**Were written isolation orders issued?..**  Y  N

If yes, where was the patient isolated? \_\_\_\_\_

Date isolation started? \_\_\_\_\_

Date isolation ended? \_\_\_\_\_

Was the patient compliant with isolation? .....  Y  N

**Were written quarantine orders issued?** .....  Y  N

If yes, where was the patient quarantined? \_\_\_\_\_

Date quarantine started? \_\_\_\_\_

Date quarantine ended? \_\_\_\_\_

Was the patient compliant with quarantine? .....  Y  N

|                     |       |        |        |              |       |                               |
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|                     |       |        |        |              |       | SSN<br>/ /                    |

**HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS**

During the 7 days prior to onset of symptoms until 4 days after rash onset, did the patient have any of the following health care exposures?

Emergency Dept. (not hospitalized)...  Y  N  U

Visit/admit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown

Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Hospital .....  Y  N  U

Visit/admit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Has patient been discharged? .....  Y  N  U

Discharge date (mm/dd/yyyy): \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

LTC facility—resident .....  Y  N  U

Visit/admit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Has patient been discharged? .....  Y  N  U

Discharge date (mm/dd/yyyy): \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Outpatient facility—patient .....  Y  N  U

Visit date (mm/dd/yyyy): \_\_\_\_\_

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Visitor to health care setting .....  Y  N  U

Visit date (mm/dd/yyyy): \_\_\_\_\_

Until date (mm/dd/yyyy): \_\_\_\_\_

Frequency:

Once

Multiple times within this time period

Daily

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Was facility notified regarding ill patient?

Yes  No  Unknown  Not applicable

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Worked or volunteered in health care or clinical setting .....  Y  N  U

Facility name \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_

Occupation:

Physician

Physician's assistant or nurse practitioner

Nurse

Laboratory

Other

Unknown

Specify work setting or volunteer duties:

Was facility notified regarding ill patient?

Yes  No  Unknown  N/A

Name of person notified \_\_\_\_\_

Date notified (mm/dd/yyyy): \_\_\_\_\_

Other, specify \_\_\_\_\_

Has the patient ever worked in a healthcare or clinical laboratory setting? .....  Y  N  U

If yes, specify and give details: \_\_\_\_\_

During the timeframe displayed above, has the patient had other blood and body fluid exposures? .....  No  Other  Unknown

Human saliva/oral secretions exposure (e.g. shared water bottle, cigarettes, eating utensils, kissing)? .....  Y  N  U

If yes, specify and give details:

**CASE INTERVIEWS/INVESTIGATIONS**

Was the patient interviewed? .....  Y  N  U

Date of interview (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Were interviews conducted

with others? .....  Y  N  U

Who was interviewed?

Were health care providers

consulted? .....  Y  N  U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? .....  Y  N  U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

**GEOGRAPHICAL SITE OF EXPOSURE**

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC

City \_\_\_\_\_

County \_\_\_\_\_

Outside NC, but within US

City \_\_\_\_\_

State \_\_\_\_\_

County \_\_\_\_\_

Outside US

City \_\_\_\_\_

Country \_\_\_\_\_

Unknown

Notes:

## **Rubella (German measles)**

### **2009 CDC Case Definition**

#### **Clinical case definition**

An illness that has all the following characteristics:

- Acute onset of generalized maculopapular rash
- Temperature greater than 99.0 F (greater than 37.2 C), if measured
- Arthralgia/arthritis, lymphadenopathy, or conjunctivitis

#### **Laboratory criteria for diagnosis**

- Isolation of rubella virus from a clinical specimen, or
- Detection of rubella-virus-specific nucleic acid by polymerase chain reaction, or
- Significant rise in serum rubella immunoglobulin G antibody level between acute- and convalescent-phase specimens, by any standard serologic assay, or
- Positive serologic test for rubella immunoglobulin M antibody

#### **Case classification**

*Suspected:* any generalized rash illness of acute onset

*Probable:* a case that meets the clinical case definition, has no or noncontributory serologic or virologic testing, and is not epidemiologically linked to a laboratory-confirmed case

*Confirmed:* a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a laboratory-confirmed case