

**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, CONGENITAL SYNDROME
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 37

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) / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

LABORATORY

Specimens for viral study Yes No

(check one) Mother Infant	Type Specimen	Date Collected	Laboratory	Specific Test Methods Used (see below)*	Test Results
<input type="checkbox"/> <input type="checkbox"/>		/ /			
<input type="checkbox"/> <input type="checkbox"/>		/ /			
<input type="checkbox"/> <input type="checkbox"/>		/ /			
<input type="checkbox"/> <input type="checkbox"/>		/ /			
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<input type="checkbox"/> <input type="checkbox"/>		/ /			
<input type="checkbox"/> <input type="checkbox"/>		/ /			
<input type="checkbox"/> <input type="checkbox"/>		/ /			

LAB TEST METHODS

a) Viral Cultures d) ELISA g) Passive Hemagglutination (PHIA)
 b) RIA e) Hemagglutination Inhibition (HAI) h) Other, specify _____
 c) IFA f) Latex Agglutination

*If antibody was performed, please specify which rubella-specific immunoglobulin antibody (IgM or IgG) was used.

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

PERIOD OF INTEREST: BIRTH OF INFANT UP TO ONE YEAR AFTER BIRTH

Is/was patient symptomatic for this disease? Y N U
 If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CHECK ALL THAT APPLY:

Cataracts Y N U
 Hearing impairment Y N U
 Developmental delay Y N U
 Congenital heart defect Y N U
 If yes, specify:
 Patent Ductus Arteriosus Y N U
 Peripheral Pulmonic Stenosis Y N U
 Congenital Heart Disease Y N U
 Pigmentary Retinopathy Y N U
 Meningoencephalitis Y N U
 Microcephaly Y N U
 Thrombocytopenic purpura
 'Blueberry Muffin' Y N U
 Enlarged Spleen Y N U

Enlarged Liver Y N U
 Radiolucent bone disease Y N U
 Hepatosplenomegaly Y N U
 Other Abnormalities: if yes, specify: _____

Was the mother of this infant/child case diagnosed with this disease? Y N U
 If yes:
 Date of diagnosis (mm/dd/yyyy): _____
 Time frame of diagnosis:
 Prior to pregnancy
 During pregnancy
 At delivery
 After delivery
 Before birth - exact period unknown
 Time frame unknown

If no:
 Was mother known not to have disease after the birth of this child? Y N U

Clinical classification
 Confirmed Stillbirth
 Infection only Suspect
 Not CRS Unknown
 Probable

INFANT BIRTH DETAILS
Infant gestational age at birth:
 Full term Premature Unknown
Number of weeks gestation _____
Birth weight _____
 Grams Pounds/ounces
 Birth weight unknown

MATERNAL INFORMATION
Date of birth of biologic mother _____
 If date of birth is unknown, provide biologic mother's age in years _____

(CONTINUED)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE (CONTINUED)

- Biologic mother's race:**
 American Indian Native Hawaiian Pacific Islander
 Alaskan Native White
 Asian Other
 Unknown Black African American

Biologic mother's Hispanic ethnicity .. Y N U
Was the child breastfed? Y N U

Was the biologic mother born outside the US? Y N U

If yes, country: _____
 Date of biologic mother's arrival in the US (mm/dd/yyyy): _____

Did the biologic mother ever have evidence of serological IgG immunity? Y N U

Test date (mm/dd/yyyy): _____
 Result:
 Positive
 Negative
 Equivocal
 Unknown

Was rubella serology performed on infant's biologic mother during pregnancy? Y N U

Date: _____

Did the biologic mother have a rubella-like illness during pregnancy? Y N U

Month of pregnancy _____
 Did the mother have a rash? Y N U
 Did the mother have a fever? Y N U

Did the mother have lymphadenopathy? Y N U

Did the mother have arthralgias/arthritis? Y N U

Was mother diagnosed with rubella by a health care provider at time of illness? Y N U

Was rubella serologically confirmed (IgG/IgM) in mother at time of illness? Y N U

Was infant's biologic mother directly exposed to a known rubella case? Y N U

Specify mother's relationship to the case: _____

Exposure from date: _____
 Until date: _____

Frequency:
 Once
 Multiple times within this time period
 Daily

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

Type of vaccine:
 MMR (combined vaccine)
 Measles
 Mumps
 Rubella

If NOT vaccinated why: _____

Vaccine date #1 (mm/dd/yyyy): ___/___/___
Vaccine date #2 (mm/dd/yyyy): ___/___/___

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: _____
 Unknown

Did the biologic mother travel outside the US during the period of interest? Y N U

Travel dates: _____

Has the infant's biological mother had any previous pregnancies..... Y N U

If yes list the country where the pregnancy occurred and the year the pregnancy occurred:

Country	Year

Give the number of children <18 years of age who were living in the household during the biologic mother's pregnancy _____

Were any of these children immunized with the rubella vaccine? Y N U

Number of children immunized _____

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): ___/___/___

Discharge/Final diagnosis: _____

Survived? Y N U
Died? Y N U

If yes:
 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): _____

Final anatomical diagnosis: _____

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

If yes, specify and list relationship to person(s): _____

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: _____

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

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? .. Y N U

Specify _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

INFANT BIRTH DETAILS

Where was the child born?
 Hospital Home
 Unknown Other _____
Hospital or facility where child was born _____

Street address of child's residence at time of birth _____

City/Town of child's residence at time of birth _____

State of child's residence at time of birth _____

Zip code of child's residence at time of birth _____

Country of child's residence at time of birth _____

Type of birth:
 Singleton >2
 Twin Unknown

Type of delivery
 Vaginal Caesarian—type unknown
 Elective Caesarian Unknown
 Non-elective Caesarian

Did the child have any underlying or previous medical conditions? Y N U
Specify _____

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 period of interest? 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: _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
Name of care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____

TREATMENT

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

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: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the period of interest 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 period of interest, did the patient attend social gatherings or crowded settings? Y N U
If yes, 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

Notes:

Notes:

In what setting was the patient most likely exposed?

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

Does the patient have any other risk factors for this disease? Y N U
Specify: _____

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						SSN / /

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the period of interest, 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): _____

Hospitalized 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 _____

During the period of interest, did the patient have 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, Congenital Syndrome

2007 CDC Case Definition

Clinical description

Presence of any defect(s) or laboratory data consistent with congenital rubella infection. Infants with congenital rubella syndrome usually present with more than one sign or symptom consistent with congenital rubella infection. However, infants may present with a single defect. Hearing impairment is the most common single defect.

Laboratory criteria for diagnosis

Isolation of rubella virus, or

Demonstration of rubella-specific immunoglobulin M (IgM) antibody, or

Infant rubella antibody level that persists at a higher level and for a longer period than expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of a twofold dilution per month).

PCR positive rubella virus

Clinical case definition

An illness, usually manifesting in infancy, resulting from rubella infection in utero and characterized by signs or symptoms from the following categories:

a) Cataracts/congenital glaucoma, congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis), hearing impairment, pigmentary retinopathy. b) Purpura, hepatosplenomegaly, jaundice, microcephaly, developmental delay, meningoencephalitis, radiolucent bone disease.

Case classification

Suspected: A case with some compatible clinical findings but not meeting the criteria for a probable case.

Probable:* A case that is not laboratory confirmed and that has any two complications listed in paragraph "a" of the clinical case definition or one complication from paragraph "a" and one from paragraph "b", and lacks evidence of any other etiology.

Confirmed: A clinically consistent case that is laboratory confirmed.

Infection only: A case that demonstrates laboratory evidence of infection, but without any clinical symptoms or signs.