



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

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

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medical provider completing clinical component of surveillance form: Name/Title: _____ Telephone: (____) _____ - _____ Fax: (____) _____ - _____ Date completed ____/____/____ | LHD CD nurse/designee completing form for submission to DPH: Name/Title (print): _____ Telephone: (____) _____ - _____ Date completed ____/____/____ LHD CD nurse/designee signature _____ |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

PERIOD OF INTEREST
 Birth of infant up to one year after birth

GENERAL DIAGNOSTIC INFORMATION
 Is/was patient symptomatic?..... Y N U
 Date of illness onset (mm/dd/yyyy): _____
 Diagnosis by health care provider or LHD (mm/dd/yyyy): _____
 Patient's health care provider for this illness _____
 Name of provider's practice or facility _____
 Telephone number for health care provider (____) _____

PREDISPOSING CONDITIONS
 Any immunosuppressive conditions? ... Y N U
 Specify _____

LOCAL HEALTH DEPARTMENT USE ONLY
Check one:
 Case definition is met.
 (Complete Part 1 and Part 2 and submit to state)
 Case definition is not met.
 (Complete Part 2 only and submit to state)

CLINICAL FINDINGS
 Poor feeding..... Y N U
 Failure to thrive..... Y N U
 Was child born with any birth defects? Y N U
 Specify: _____
 Skin rash Y N U
 Onset date (mm/dd/yyyy): _____
 Observed by health care provider..... Y N U
 Duration: _____
 Unit: Hours Days Weeks
 Thrombocytopenic purpura 'Blueberry Muffin'..... Y N U
 Other symptoms, signs, clinical findings, or complications consistent with this illness? Y N U
 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

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

MATERNAL INFORMATION
 Date of birth of biologic mother _____
 If date of birth is unknown, provide biologic mother's age in years _____
Biologic mother's race:
 American Indian
 Alaskan Native
 Asian
 Black African American
 Native Hawaiian Pacific Islander
 White
 Other _____
 Unknown
 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

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 _____

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
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MATERNAL INFORMATION (CONTINUED)

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: _____

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

Travel dates: _____

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 _____

Comments: _____

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
 ICU
 Other _____
 Unknown

HOSPITALIZATION INFORMATION

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): ____/____/____

ICU admission? Y N U

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

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

If yes, specify: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Status at time of report:
 Fully recovered
 Survived but experiencing sequelae (residual deficit from illness) at time of report

Died? Y N U

If yes:
Died from this illness? Y N U

If yes, location of death:
 Home
 Emergency Department
 Hospital ICU
 Hospital inpatient
 En route to hospital
 Long-term care facility
 Other, specify: _____
 Unknown

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): _____

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: _____

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 _____
 Refugee / Immigrant
 Military related Student / Teacher
 Visit to family / friends Unknown
 Peace corps 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: _____

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: _____

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CHILD CARE/SCHOOL/COLLEGE

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

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, has the patient attended 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 for this disease? Y N U
 Specify: _____

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 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

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 If yes, specify:

| | | | | | | |
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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

Is the patient suspected of being part of a common source outbreak? Y N U

Notes:

VACCINES

Has the patient ever received rubella-containing vaccine? Y N U
 If yes, date of vaccination (mm/dd/yyyy): _____ Unknown
 Dose administered: _____
 Vaccine type: _____
 Manufacturer: _____
 Product/trade name: _____
 Lot number: _____
 Vaccine date unknown Y N
 If yes, number of doses received on or after first birthday: _____

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: _____
 Unknown
 *Any vaccine on a medical record should be recorded in the NCIR

DIAGNOSTIC TESTING

LABORATORY

Specimens for viral study Yes No

| (check one) Mother | (check one) 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.

2007 CDC/CSTE CASE DEFINITION

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.

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).

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.