West Virginia Bureau for Public Health — Your Health Your Safety Our Purpose
Department of Health & Human Resources

Congenital Rubella Syndrome (CRS)

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade:_____ Employer/School:_____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:*_____ *Phone:* _____

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐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 infant hospitalized for this illness? ☐ **Y** ☐ **N** ☐ **U**
If yes: Hospital name: _____ Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Condition

Diagnosis date: __ / __ / ____ Illness onset date: __ / __ / ____
Date of last evaluation by healthcare provider: __/__/____
Age Congenital Rubella Syndrome diagnosed: _____ ☐ Years ☐ Months ☐ Weeks ☐ Days ☐ Hours ☐ Minutes ☐ Unknown
Gestational age at birth (weeks): _____ Birth weight: _____ ☐ g ☐ kg ☐ lbs ☐ oz

Did/does patient have:

Y	N	U		Y	N	U		Y	N	U	
☐	☐	☐	Cataracts	☐	☐	☐	Hearing impairment (loss)	☐	☐	☐	Congenital Heart Disease
☐	☐	☐	Patent Ductus Arteriosus	☐	☐	☐	Peripheral Pulmonic Stenosis	☐	☐	☐	Congenital Glaucoma
☐	☐	☐	Pigmentary Retinopathy	☐	☐	☐	Other type of Congenital Heart Disease (specify): _____				

Y	N	U		Y	N	U		Y	N	U	
☐	☐	☐	Developmental Delay/Mental Retardation	☐	☐	☐	Meningoencephalitis	☐	☐	☐	Microcephaly
☐	☐	☐	Purpura	☐	☐	☐	Enlarged spleen	☐	☐	☐	Enlarged liver
☐	☐	☐	Radiolucent bone disease	☐	☐	☐	Neonatal jaundice	☐	☐	☐	Low platelets
☐	☐	☐	Dermal Erythropoiesis (aka Blueberry Muffin Syndrome)	☐	☐	☐	Other abnormalities (specify): _____ _____				

Did infant die from CRS or complications associated with CRS? ☐ **Y** ☐ **N** ☐ **U**
If yes, primary cause of death: _____ If yes, secondary cause of death: _____
Was an autopsy performed? ☐ **Y** ☐ **N** ☐ **U**
Final anatomical diagnosis of death from autopsy report: _____

Clinical notes

Y=Yes N=No U=Unknown

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

Y N U

☐ ☐ ☐ Was laboratory testing done for rubella on this infant?

☐ ☐ ☐ 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 (1st)					
IgM (2nd)					
IgG					
IgG – Acute					
IgG – Convalescent					
Viral Isolation					
PCR					
Other (specify)					
Other (specify)					
Other (specify)					

Lab notes

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: _________________

MATERNAL MEDICAL HISTORY DURING THIS PREGNANCY

Has the mother ever been reported as a rubella case? ☐ **Y** ☐ **N** ☐ **U**
Mother's age at delivery of this pregnancy (in years): _____
Mother's occupation at time of this infant's conception: __________________________
Did the mother attend a family planning clinic prior to conception of this infant? ☐ **Y** ☐ **N** ☐ **U**

Mother immunized with rubella-containing vaccine? ☐ **Y** ☐ **N** ☐ **U**
Date vaccinated: __/__/____ Source of vaccine: ☐ Private sector ☐ Public sector ☐ Unknown
Source of information: ☐ Mother only ☐ Physician ☐ School ☐ Other (specify): _______________________

Mother's Country of birth? ___________________________________ Length of time mother has been in the US (in years)? _____
Number of previous pregnancies: _____ Number of live births (total): _____
Has mother given birth previously in the US? ☐ **Y** ☐ **N** ☐ **U**
If yes, number of births delivered in US: _____ If yes, list the dates (years): _____________________________

Number of children less than 18 years of age living in household during this pregnancy: _____
Were any of the children immunized with a rubella-containing vaccine? ☐ **Y** ☐ **N** ☐ **U** If yes, how many: _____
Was prenatal care obtained for this pregnancy? ☐ **Y** ☐ **N** ☐ **U** If yes, date of first prenatal visit for this pregnancy: __/__/____
Where was prenatal care obtained for this pregnancy? ☐ Private sector ☐ Public sector ☐ Unknown
Was there a rubella-like illness during this pregnancy? ☐ **Y** ☐ **N** ☐ **U**
Month of pregnancy in which symptoms first occurred: _____
Was rubella diagnosed by a physician at time of illness? ☐ **Y** ☐ **N** ☐ **U**
If rubella not diagnosed by physician, who made the diagnosis: ____

MATERNAL ILLNESS DURING THIS PREGNANCY

Y N U Did the mother have any of the following:

☐ ☐ ☐ Rash If yes, rash onset date: __/__/____
☐ ☐ ☐ Fever
☐ ☐ ☐ Lymphadenopathy
☐ ☐ ☐ Arthralgia/Arthritis
☐ ☐ ☐ Other (specify): _____

☐ ☐ ☐ Does mother know where she might have been exposed to rubella? If yes, where was the disease acquired: ☐ Unknown
☐ Indigenous, within jurisdiction ☐ Out of country ☐ Out of jurisdiction, from another jurisdiction ☐ Out of state
If exposure occurred out of country, specify (country, county, city): _____
If exposure location is unknown, did mother travel outside the US during the 1st trimester? ☐ **Y** ☐ **N** ☐ **U**
If yes, specify location (country, county, city): _____
Dates of travel: __/__/____ through __/__/____ ☐ Unknown

☐ ☐ ☐ Was the mother directly exposed to a confirmed rubella case? If yes, date of exposure: __/__/____
If yes, specify the relationship: ☐ Brother ☐ Father ☐ Friend ☐ Grandparent ☐ Mother ☐ Neighbor ☐ Sister
☐ Spouse ☐ Unknown ☐ Other (specify): _____

☐ ☐ ☐ Did the mother have serological testing prior to this pregnancy?

☐ ☐ ☐ Was rubella lab testing performed for the mother in conjunction with this pregnancy?
If yes, was rubella serologically confirmed at time of illness? ☐ **Y** ☐ **N** ☐ **U** If yes, date of confirmation: __/__/____
Result of confirmation: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Unknown ☐ Not done

☐ ☐ ☐ Did mother have serologic testing for rubella immunity prior to exposure?
If yes, date: __/__/____ Result: ☐ Susceptible ☐ Immune ☐ Unknown
*If more than 1 serologic test, please include dates & results for each test in the notes section

Was this delivery a live birth with infection only ☐ OR a still birth ☐

Name of physician responsible for child's care: _____

Address: _____ Phone: _____

Source of report: ☐ Private MD ☐ Death record ☐ Birth record ☐ Laboratory record ☐ Hospital ☐ Other (specify): _____

PUBLIC HEALTH ACTIONS/NOTES

☐ Public health action (education, prevention, intervention, etc.) done. If yes, specify date __/__/____.
☐ Lost to follow-up

Y=Yes N=No U=Unknown

Contact Tracing Sheet									
Name/Contact Information (including guardian information for minors)	Contact or source?	Date of Birth (mm/dd/yyyy)	Sex	Relation-ship to case?	Number of doses of rubella-containing vaccine?	Is this a case? (Y/N)	Rash onset date? **(mm/dd/yyyy)**	Immunity confirmed before/within 7 days after 1st exposure? (Y/N)	If no or unknown, action taken

Exposure period = 21 days before-14 days before rash onset
Infectious period = 7 days before – 7 days after rash onset

Number of contacts in any setting recommended PEP: _____

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