Tennessee Department of Health

Congenital Rubella Syndrome Case Report

Draft, Revised: 09/2010

Please fill out all three pages of this form as complete as possible. Anything that appears in **red** is not available for data entry into NEDSS. However, you may find those fields helpful in your investigation. Notify Central Office Immunization Program regarding this case.

DEMOGRAPHICS

CASE ID#:_____

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____

Reported Age: _____ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Phone - Home: _____ **Work:** _____ **Cell:** _____

Ethnicity: □ Hispanic □ Not Hispanic

Race: □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Other (_____)

Employer/School/Daycare: _____ **Occupation:** _____

ALTERNATE CONTACT INFORMATION

Last Name: _____ **First:**_____ **Relationship:** □ Parent □ Spouse □ Household Member □ Friend □ Other _____

Phone #:_____

INVESTIGATION SUMMARY

Jurisdiction: □ East Tennessee □ Mid-Cumberland □ Northeast □ South Central □ Southeast □ West Tennessee □ Upper Cumberland □ Nashville/Davidson □ Chattanooga/Hamilton □ Knoxville/Knox □ Jackson/Madison □ Memphis/Shelby □ Sullivan □ Out of Tennessee □ Unassigned

INVESTIGATION SUMMARY

Investigation Start Date: _____/_____/_____

Investigation Status: □ Open □ Closed

Investigator: _____

Date Assigned to Investigation: _____/_____/_____

Physician: _____

Physician's Phone: _____

REPORTING SOURCE

Date of Report: _____/_____/_____

Reporting Source: _____

Earliest Date Reported to County: _____/_____/_____

Earliest Date Reported to State: _____/_____/_____

Reporter: _____

CLINICAL INFORMATION

HOSPITAL INFORMATION

Was the patient hospitalized for this illness? □ Yes □ No □ Unknown

Hospital: _____

Admission Date:____/____/_____ **Discharge Date:** ____/____/_____

Diagnosis Date: ____/____/_____ **Illness Onset Date:** ____/____/_____

Date of last evaluation by a healthcare provider: ____/____/_____

INFANT INFORMATION

Birth State/Country:_____

Gestational age at birth:_____ **weeks**

Infant's age at diagnosis:_____

Birth weight:_____

CLINICAL CHARACTERISTICS

GROUP A **Did/does the infant have (check all that apply):**

□ **Cataracts** □ **Hearing impairment (loss)** □ **Congenital heart disease** □ **Patent ductus arteriosus**

□ **Congenital glaucoma** □ **Peripheral pulmonic stenosis** □ **Pigmentary retinopathy**

□ **Other type of congenital heart disease:** _____

GROUP B **Did/does the infant have (check all that apply):**

□ **Developmental delay or mental retardation** □ **Meningoencephalitis** □ **Microcephaly** □ **Purpura**

□ **Enlarged spleen** □ **Enlarged liver** □ **Radiolucent bone disease** □ **Neonatal jaundice** □ **Low platelets**

□ **Dermal erythropoiesis (blueberry muffin syndrome)** □ **Other abnormalities:** _____

Did the infant die from CRS or complications associated with CRS? □ Yes □ No □ Unknown

Cause from death certificate: **Primary:**_____ **Secondary**:_____

Was an autopsy performed? □ Yes □ No □ Unknown

Final anatomical diagnosis of death from autopsy report?_____

COMMENTS

_____

LABORATORY

CASE ID#:_____

Was laboratory testing done for rubella? □ Yes □ No □ Unknown *(If yes, complete the table below.)*

	IgM Serum	Acute IgG Serum	Convalescent IgG Serum	RT-PCR Performed?	Virus Isolation Performed?	Other Lab Tests
Was testing performed?	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown
Name of Laboratory						
Date Specimen Taken						
Result of Test	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ No significant rise in IgG □ Significant rise in IgG □ Pending □ Indeterminate □ Unknown		□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown

Were the clinical specimens sent to CDC for genotyping (molecular typing)? □ Yes □ No □ Unknown **Date sent for genotyping:** _____/_____/_____

Was CRS virus genotype sequenced? □ Yes □ No □ Unknown **Specimen Type:**_____

MOTHER'S MEDICAL HISTORY DURING THIS PREGNANCY

Has the mother every been reported as a rubella case? □ Yes □ No □ Unknown **Mother's age at delivery this pregnancy:**_____years

Mother's occupation at time of this infant's conception:_____

Did the mother attend a family planning clinic prior to conception of this child? □ Yes □ No □ Unknown

Mother immunized with rubella-containing vaccine? □ Yes □ No □ Unknown **Date vaccinated**:_____/_____/_____

Source of information: □ Mother □ Physician □ School □ Other:_____

Source of Vaccine: □ Private sector □ Public sector □ Unknown

Mother's birth country: _____ **Length of time mother has been in the US**: _____ years

Number of previous pregnancies:_____ **Number of live births (total):**_____

Has mother given birth previously in the US? □ Yes □ No □ Unknown

If yes, number of births delivered in the US: _____

If yes, list the dates (years): _____; _____; _____; _____; _____; _____

Number of children <18 years of age living in household during this pregnancy?_____

Were any of the children immunized with rubella-containing vaccine? □ Yes □ No □ Unknown **If yes, how many?**_____

Was prenatal care obtained for this pregnancy? □ Yes □ No □ Unknown

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? □ Yes □ No □ Unknown

Month of pregnancy in which symptoms first occurred:_____

Was rubella diagnosed by a physician at time of illness? □ Yes □ No □ Unknown **If no, by whom:**_____

COMMENTS

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CLINICAL FEATURES OF MATERNAL ILLNESS DURING THIS PREGNANCY

CASE ID#:_____

Did the mother have any of the following? □ Rash (Onset date _____/_____/_____) □ Fever Lymphadenopathy
□ Arthralgia/Arthritis □ Other:_____

Does the mother know where she might have been exposed to rubella? □ Yes □ No □ Unknown

Where was the disease acquired?: □ Indigenous (within jurisdiction) □ Out of country □ Out of state □ Out of jurisdiction □ Unknown

Imported Country: _____ **Imported State:** _____

Imported City: _____ **Imported County:** _____

Was the mother directly exposed to a confirmed rubella case? □ Yes □ No □ Unknown

If yes, specify relationship of individual to the mother:_____

Date of exposure:_____/_____/_____

Did the mother have serological testing prior to this pregnancy? □ Yes □ No □ Unknown

Was rubella lab testing performed for the mother in conjunction with this pregnancy? □ Yes □ No □ Unknown

Was rubella serologically confirmed at time of illness? □ Yes □ No □ Unknown **Date of confirmation:** ____/____/_____

Result of confirmation: □ Indeterminate □ Negative □ Not done □ Pending □ Positive □ Unknown

Confirmation Method: □ Clinical Diagnosis □ Epidemiologically-linked □ Lab Confirmed □ Other (_____)

Case Status: □ Confirmed □ Probable □ Suspect

COMMENTS

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FOR ADMINISTRATIVE USE ONLY:

Date of Interview: ____/____/_____	**Was the case entered into NEDSS?** □ Yes □ No □ Unknown
Interviewer's Name: _____	**Date entered into NEDSS:** ____/____/_____
Other Notes: _____	**Data Entry Person's Name:** _____