



Rubella

County _____

LHJ Use ID _____
 Reported to DOH Date ____/____/____
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 DOH Outbreak #: _____

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No DK Date of interview ____/____/____

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age ____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms

Y N DK NA
 Fever Highest measured temp: ____ °F
 Type: Oral Rectal Other: ____ Unk
 Runny nose (coryza)
 Rash (maculopapular) Onset date: ____/____/____
 Duration: ____ days
 Describe rash progression: _____
 Does the rash itch? Yes__ No__
 Headache
 Malaise

Y N DK NA
 Hospitalized at least overnight for this illness
 Hospital name _____
 Admit date ____/____/____ Discharge date ____/____/____
Y N DK NA
 Died from illness Death date ____/____/____
 Autopsy Place of death _____

Vaccination

Y N DK NA
 Ever received rubella containing vaccine
 Dose 1 Type: _____ Date received: ____/____/____
 Dose 2 Type: _____ Date received: ____/____/____
 Dose 3 Type: _____ Date received: ____/____/____
 Vaccine up to date for rubella
 Number doses on or after 1st birthday: _____
 Vaccine series not up to date reason:
 Religious exemption Medical contraindication
 Philosophical exemption
 Previous infection confirmed by laboratory
 Previous infection confirmed by physician
 Parental refusal Other: _____ Unk

Clinical Findings

Y N DK NA
 Conjunctivitis
 Lymphadenopathy Onset date: ____/____/____
 Cervical Suboccipital
 Postauricular Other: _____
 Arthritis or arthralgia
 Rash observed by health care provider
 Rash distribution: _____
 Generalized Localized On palms and soles
 Patechial Macular Papular
 Pustular Vesicular Bullous
 Other: _____
 Congenital Rubella Syndrome (CRS)
 Hemorrhagic signs
 Pneumonia or pneumonitis
 Encephalitis or encephalomyelitis
 Leukopenia
 Thrombocytopenia
 Complications
 Specify: _____

Laboratory

Collection date ____/____/____
 Source _____
P N I O NT
 Rubella virus culture (clinical specimen)
 Rubella IgG with significant rise (acute and convalescent serum pair)
 Rubella IgM
 Rubella virus nucleic acid detection (PCR)
 Tests to rule out other agents
 Agent/results: _____ Date: ____/____/____
 Agent/results: _____ Date: ____/____/____

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset: -23 -12

Calendar dates:

o
n
s
e
t

Contagious period
7 days before to 7 days after rash onset *

* Infants born with congenital rubella syndrome may shed for months after birth

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Destinations/Dates: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with recent foreign arrival Specify country: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the case know anyone else with similar symptoms or illness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed or probable case</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congregate living <input type="checkbox"/> Barracks <input type="checkbox"/> Corrections <input type="checkbox"/> Long term care <input type="checkbox"/> Dormitory <input type="checkbox"/> Boarding school <input type="checkbox"/> Camp <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visited health care setting 1 - 3 weeks preceding onset Facility name: _____ Number of visits: _____ Date(s): ___/___/___</p> <p><input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Exposure setting identified: <input checked="" type="checkbox"/> Child care <input type="checkbox"/> School <input type="checkbox"/> Doctor's office <input checked="" type="checkbox"/> Hospital ward <input type="checkbox"/> Hospital ER <input checked="" type="checkbox"/> Hospital outpatient clinic <input type="checkbox"/> Home <input type="checkbox"/> College <input type="checkbox"/> Work <input type="checkbox"/> Military <input type="checkbox"/> Correction facility <input type="checkbox"/> Church <input type="checkbox"/> International travel <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown</p>
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Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PUBLIC HEALTH ISSUES

Y N DK NA

If female, is case pregnant Weeks gestation: _____
Previous rubella titer
 Pos Neg DK NA Year: _____

Any contact with pregnant woman

Attends child care or preschool

Employed in child care or preschool

Do any household members work at or attend child care or preschool

Documented transmission from this case
 Child care School Doctor's office
 Hospital ward Hospital ER
 Hospital outpatient clinic Home
 College Work Military
 Correction facility Church
 International travel Other: _____ Unk

PUBLIC HEALTH ACTIONS

- Exclude exposed susceptibles from work/school for incubation period
- Evaluate immune status of close contacts
- Assess possibility of pregnancy in female contacts

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ___/___/___

Local health jurisdiction _____ Record complete date ___/___/___

Rubella: case defining variables are in **bold**. Answers are: Yes, No, Unknown to case, Not asked /Not answered