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.

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
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			
☐	☐		/ /			

LAB TEST METHODS

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

*If antibody was performed, please specify which rubella-specific immunoglobin 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 _____

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

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:

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:

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, did the patient attend social gatherings or crowded settings? ..... ☐ Y ☐ N ☐ U
If yes, specify:_____

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

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

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

2010 Case Definition

CSTE Position Statement Number: 09-ID-61

Case classification

Suspected: An infant that does not meet the criteria for a probable or confirmed case but who has one of more of the following clinical findings:

- cataracts or congenital glaucoma,
- congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis),
- hearing impairment,
- pigmentary retinopathy
- purpura,
- hepatosplenomegaly,
- jaundice,
- microcephaly,
- developmental delay,
- meningoencephalitis, or
- radiolucent bone disease.

Probable*: An infant without an alternative etiology that does not have laboratory confirmation of rubella infection but has at least 2 of the following:

- cataracts or congenital glaucoma,*
- congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis),
- hearing impairment, or
- pigmentary retinopathy;

OR

An infant without an alternative etiology that does not have laboratory confirmation of rubella infection but has at least one or more of the following:

- cataracts or congenital glaucoma,*
- congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis),
- hearing impairment, or
- pigmentary retinopathy

AND one or more of the following:

- purpura,
- hepatosplenomegaly,
- jaundice,
- microcephaly,
- developmental delay,
- meningoencephalitis, or
- radiolucent bone disease.

Confirmed: An infant with at least one symptom (listed above) that is clinically consistent with congenital rubella syndrome; and laboratory evidence of congenital rubella infection as demonstrated by:

- isolation of rubella virus, or
- detection 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), or
- a specimen that is PCR positive for rubella virus.

Case classification (cont.)

Infection only: An infant without any clinical symptoms or signs but with laboratory evidence of infection as demonstrated by:

- isolation of rubella virus, or
- detection 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), or
- a specimen that is PCR positive for rubella virus.

*In probable cases, either or both of the eye-related findings (cataracts and congenital glaucoma) count as a single complication. In cases classified as infection only, if any compatible signs or symptoms (e.g., hearing loss) are identified later, the case is reclassified as confirmed.

Epidemiologic classification of internationally-imported and U.S.-acquired

Congenital Rubella Syndrome (CRS) cases will be classified epidemiologically as internationally imported or U.S.-acquired, according to the source of infection in the mother, using the definitions below, which parallel the classifications for rubella cases.

Internationally imported case: To be classified as an internationally imported CRS case, the mother must have acquired rubella infection outside the U.S. or in the absence of documented rubella infection, the mother was outside the United States during the period when she may have had exposure to rubella that affected her pregnancy (from 21 days before conception and through the first 24 weeks of pregnancy).

U.S.-acquired case: A US-acquired case is one in which the mother acquired rubella from an exposure in the United States. U.S.-acquired cases are subclassified into four mutually exclusive groups:

- **Import-linked case:** Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.
- **Import-virus case:** A case for which an epidemiologic link to an internationally imported case was not identified but for which viral genetic evidence indicates an imported rubella genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any rubella virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.
- **Endemic case:** A case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of rubella virus transmission continuous for ≥12 months within the United States.
- **Unknown source case:** A case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases

.

States may also choose to classify cases as “out-of-state-imported” when imported from another state in the United States. For national reporting, however, cases will be classified as either internationally imported or U.S.-acquired.