

NAME (Last, First)				Hospital Record No.	
Address (Street and No.)		City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/Lab		Address			Phone

----- DETACH HERE and transmit only lower portion if sent to CDC -----

Rubella Surveillance Worksheet

County		State		Zip		Country of Birth					
Birth Date <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Age <input type="text"/> <input type="text"/> <input type="text"/> Unk = 999		Age Type <input type="checkbox"/> 0 = 0-120 years <input type="checkbox"/> 3 = 0-28 days <input type="checkbox"/> 1 = 0-11 months <input type="checkbox"/> 9 = Age unknown <input type="checkbox"/> 2 = 0-52 weeks		Ethnicity <input type="checkbox"/> H = Hispanic <input type="checkbox"/> N = Not Hispanic <input type="checkbox"/> U = Unknown		Race <input type="checkbox"/> N = Native Amer./Alaskan Native W = White <input type="checkbox"/> A = Asian/Pacific Islander O = Other <input type="checkbox"/> B = African American U = Unknown		Sex <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female <input type="checkbox"/> U = Unknown	

Event Date <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Event Type <input type="checkbox"/> 1 = Onset Date <input type="checkbox"/> 4 = Reported to County <input type="checkbox"/> 2 = Diagnosis Date <input type="checkbox"/> 5 = Reported to State or <input type="checkbox"/> 3 = Lab Test Date <input type="checkbox"/> 9 = MMWR Report Date <input type="checkbox"/> 9 = Unknown		Outbreak Associated <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unk = 999		Reported <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Imported <input type="checkbox"/> 1 = Indigenous <input type="checkbox"/> 2 = International <input type="checkbox"/> 3 = Out of State <input type="checkbox"/> 9 = Unknown		Report Status <input type="checkbox"/> 1 = Confirmed <input type="checkbox"/> 2 = Probable <input type="checkbox"/> 3 = Suspect <input type="checkbox"/> 9 = Unknown	
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Any Rash? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Rash Onset <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Rash Duration <input type="text"/> <input type="text"/> <input type="text"/> 0 - 30 Days 99 = Unknown	
Fever? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		If Recorded, Highest Measured Temp. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 36.0 - 110.0 Degrees 999.9 = Unknown			
Arthralgia/Arthritis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Lymphadenopathy? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Conjunctivitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	

Encephalitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Arthralgia/Arthritis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown			
Thrombocytopenia? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Death? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Other Complications? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown If Yes, Please Specify:	
Hospitalized? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		Days Hospitalized <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 - 998 999 - Unknown			

Was Laboratory Testing For Rubella Done? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown			
Date IgM Specimen Taken <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Result <input type="checkbox"/> P = Positive <input type="checkbox"/> E = Pending <input type="checkbox"/> N = Negative <input type="checkbox"/> X = Not Done <input type="checkbox"/> I = Indeterminate <input type="checkbox"/> U = Unknown	
Date IgG Acute Specimen Taken <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Date IgG Convalescent Specimen Taken <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	
Result <input type="checkbox"/> P = Significant Rise in IgG <input type="checkbox"/> N = No Significant Rise in IgG <input type="checkbox"/> I = Indeterminate <input type="checkbox"/> E = Pending <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown		Other Lab Result <input type="checkbox"/> P = Significant Rise in IgG <input type="checkbox"/> N = No Significant Rise in IgG <input type="checkbox"/> I = Indeterminate <input type="checkbox"/> X = Not Done <input type="checkbox"/> E = Pending <input type="checkbox"/> U = Unknown Specify Other Lab Method:	

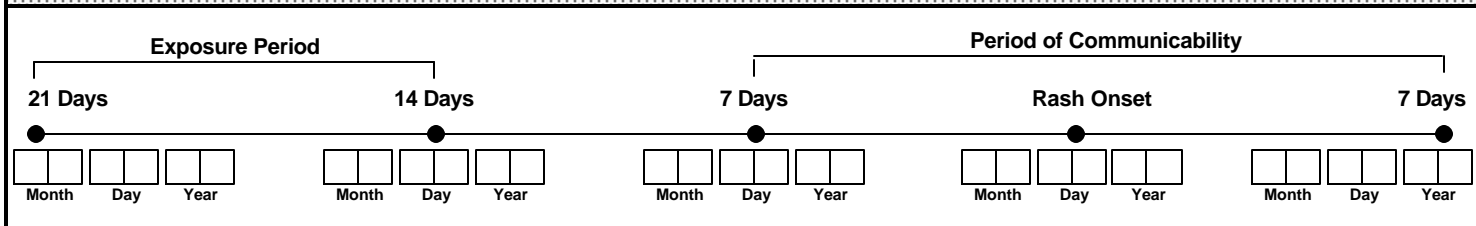
Vaccinated? (Received rubella-containing vaccine?) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown				
Vaccination Date <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Vaccine Type <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Manuf. <input type="text"/> <input type="text"/> <input type="text"/>	Lot Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Vaccine Type Codes A = MMR B = Rubella O = Other U = Unknown		Vaccine Manufacturer Codes M = Merck O = Other U = Unknown		
Number of doses received ON or AFTER 1st birthday <input type="text"/>				
If Not Vaccinated, What Was The Reason? <input type="checkbox"/>				
1 = Religious Exemption 2 = Medical Contraindication 3 = Philosophical Objection 4 = Lab. Evidence of Previous Disease 5 = MD Diagnosis of Previous Disease		6 = Under Age For Vaccination 7 = Parental Refusal 8 = Other 9 = Unknown		

Date First Reported to a Health Department <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Date Case Investigation Started <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year		Outbreak Related? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		If Yes, Outbreak Name _____	
Transmission Setting (Where did this case acquire rubella?)							
<input type="checkbox"/> 1 = Day Care <input type="checkbox"/> 2 = School <input type="checkbox"/> 3 = Doctor's Office <input type="checkbox"/> 4 = Hospital Ward <input type="checkbox"/> 5 = Hospital ER		<input type="checkbox"/> 6 = Hospital Outpatient Clinic <input type="checkbox"/> 7 = Home <input type="checkbox"/> 8 = Work <input type="checkbox"/> 9 = Unknown <input type="checkbox"/> 10 = College		<input type="checkbox"/> 11 = Military <input type="checkbox"/> 12 = Correctional Facility <input type="checkbox"/> 13 = Church <input type="checkbox"/> 14 = International Travel <input type="checkbox"/> 15 = Other		Source of Exposure For Current Case (Enter State ID if source was an in-state case; enter Country if source was out of U.S.; enter State if source was out-of-state) _____	
If Other, Specify Transmission Setting: _____							
Were Age and Setting Verified? (Is age appropriate for setting, i.e. aged 49 years and in day care, etc.) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown						Epi-Linked to Another Confirmed or Probable Case? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	

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PREGNANT WOMEN	Was The Case Pregnant? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Number of Weeks Gestation (or Trimester) at Onset of Illness	<input type="text"/> <input type="text"/> <input type="text"/>	1 st = First Trimester 2 nd = Second Trimester 3 rd = Trimester	1 = 1 Week 2 = 2 Weeks 3 = 3 Weeks Etc. – continue up to 45 weeks
	Prior Evidence of Serological Immunity? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Year of Test <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OR		Age of Patient at Time of Test <input type="text"/> <input type="text"/> 0 -50 99 - Unknown
	Was Previous Rubella Serologically Confirmed? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Year of Disease <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OR		Age of Patient at Time of Disease <input type="text"/> <input type="text"/> 0 -50 99 - Unknown

The information below is epidemiologically important but not included on NETSS screens



Contacts to case in case's infectious period (7 days before to 7 days after rash onset) who are in 1st 5 months of pregnancy

<u>Name</u>	<u>Address/Phone</u>	<u>Documented Prior Rubella Immunization?</u>	<u>If Yes, Date</u>	<u>Documented Rubella Seropositivity Before Or Within 7 Days After First Exposed</u>	<u>If No or Unknown, Action Taken – Rubella Serology, etc.</u>
_____	_____	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	<input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	_____
_____	_____	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	<input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	_____
_____	_____	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	<input type="text"/> <input type="text"/> <input type="text"/> Month Day Year	<input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	_____

Group contacts to case in case's infectious period (7 days before to 7 days after rash onset), i.e., households, child care center, school, college, workplace, jail/prison, physician's office/clinic/hospital/emergency room, etc.

<u>Name of Group/Site</u>	<u>Address/Phone</u>	<u>Notes</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Clinical Case Definition:

An illness that has all of the following characteristics: acute onset of generalized maculopapular rash, temperature > 99° F (> 37° C), if measured, and arthralgia/arthritis, lymphadenopathy, or conjunctivitis.

Case Classification:

Suspected: any generalized rash illness of acute onset

Probable: a case that meets the clinical case definition, has no or noncontributory serologic or virologic testing, and is not epidemiologically linked to a laboratory-confirmed case

Confirmed: a case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a laboratory-confirmed case