



## RUBELLA (GERMAN MEASLES) CASE REPORT

### PATIENT DEMOGRAPHICS

Patient name—last		first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/>			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address—number, street				City	State	ZIP code	County	
Telephone number Home ( )				Work ( )		Email:		
<b>ETHNICITY (check one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Unknown		<b>RACE (check all that apply)</b> <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <input type="checkbox"/> Asian: <i>Please specify:</i> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian _____ <input type="checkbox"/> Pacific Islander: <i>Please specify:</i> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____						
Country of birth				Country of residence				

### COMMON LHD TRACKING DATA

CMRID Number	IZB Case ID Number	WebCMR ID Number	
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case	Reporter telephone ( )
Case investigator completing form	Investigator telephone ( )	Investigator's jurisdiction	

### SIGNS AND SYMPTOMS

Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rash onset date ____/____/____	Rash duration _____ days	Generalized rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Origin on body	Direction of spread
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Fever onset date ____/____/____	Was temperature taken <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Was temperature >99.0F (37.2C) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If temperature not taken, skin was <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Normal <input type="checkbox"/> Unknown	
Arthralgia/arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Lymphadenopathy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Conjunctivitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other symptoms			Diagnosis date ____/____/____	
Does case meet clinical criteria for further investigation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<b>CASE MEETS CDC/CSTE CLINICAL CRITERIA? (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

### COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, number of days hospitalized	Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, date of death ____/____/____
Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other complications			

### LABORATORY TESTS

Lab tests done for rubella <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>CASE LAB CONFIRMED (FOR LHD USE)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>CASE LAB CONFIRMED (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>LAB RESULT CODES</b> P = Positive N = Negative – Antibody not detected I = Indeterminate E = Pending X = Not Done U = Unknown		
Serology performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen date ____/____/____	Result interpretation			
IgM	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U			
IgG (acute)	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U			
IgG (convalescent)	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U			
Specimen taken for virus isolation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen Source <input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Specimen date ____/____/____	Virus isolated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of Lab:	
Specimen sent to CDC for genotyping <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date sent ____/____/____	Virus Genotype			
Other lab tests performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other lab test specimen date ____/____/____	Specify other lab tests	Other lab test results		

**VACCINATION/MEDICAL HISTORY**

Received one or more doses of rubella containing vaccine  Yes  No  Unknown If yes, number of doses \_\_\_\_\_

Dates of vaccination—Dose 1: \_\_\_/\_\_\_/\_\_\_ Dose 2: \_\_\_/\_\_\_/\_\_\_ Dose 3: \_\_\_/\_\_\_/\_\_\_

Reason not vaccinated (check all that apply)

1  Personal Beliefs Exemption (PBE) 4  Lab confirmation of previous disease 7  Delay in starting series or between doses  
 2  Permanent Medical Exemption (PME) 5  MD diagnosis of previous disease 8  Other  
 3  Temporary Medical Exemption 6  Under age for vaccination 9  Unknown

Prior MD diagnosed rubella (see reason 5)  Yes  No  Unknown Pregnant  Yes  No  Unknown Immunocompromised  Yes  No  Unknown

**EPIDEMIOLOGICAL EXPOSURE HISTORY**

Setting (check all that apply)

1  Day care 4  Hospital Ward 7  Home 10  College 13  Church  
 2  School 5  Hospital ER 8  Work 11  Military 14  International travel  
 3  Doctor's office 6  Outpatient hospital clinic 9  Unknown 12  Correctional facility 15  Other

Recent travel or arrival from other country or state within 23 days of rash onset?  Yes  No  Unknown

Countries or states visited: \_\_\_\_\_ Dates in countries or states visited: \_\_\_\_\_ Date of arrival in California: \_\_\_/\_\_\_/\_\_\_

Close contact with person(s) with rash or person(s) with congenital rubella syndrome (CRS) 12-23 days before rash onset?  Yes  No  Unknown

	Name	Rash Onset Date	Relationship	Age (Years)	Same Household
1		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing work sheet.

Epi-linked to a lab-confirmed case?  Yes  No  Unknown Case Name or Case ID: \_\_\_\_\_ Outbreak related  Yes  No  Unknown Outbreak Name or Location: \_\_\_\_\_

Import status  Indigenous  Out-of-state import  International Import If case is indigenous, is case  Import-linked (linked to imported case)  Endemic  Unknown Source  Imported virus (viral genetic evidence indicates an imported genotype) If case is imported, describe source: \_\_\_\_\_

**CONTACT INVESTIGATION**

Setting (check all that apply)

1  Day care 4  Hospital Ward 7  Home 10  College 13  Church  
 2  School 5  Hospital ER 8  Work 11  Military 14  International travel  
 3  Doctor's office 6  Outpatient hospital clinic 9  Unknown 12  Correctional facility 15  Other

Number of susceptible contacts: \_\_\_\_\_ Number of susceptible contacts who are pregnant: \_\_\_\_\_ Close contacts who have rash 12-23 days after exposure to case (list below)  Yes  No  Unknown

	Name	Rash Onset Date	Relationship	Age (Years)	Same Household
1		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3		___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing work sheet.

**CASE CLASSIFICATION (FOR LHD USE)**  Confirmed  Probable  Suspect  Not a case  Unknown **CASE CLASSIFICATION (FOR STATE USE ONLY)**  Confirmed  Probable  Suspect  Not a case  Unknown

**RUBELLA (German measles) 2010 CASE DEFINITION** CSTE Position Statement Number: 09-ID-55

**Case classification**

**Suspected:** Any generalized rash illness of acute onset that does not meet the criteria for probable or confirmed rubella or any other illness

**Probable:** In the absence of a more likely diagnosis, an illness characterized by all of the following: acute onset of generalized maculopapular rash; **AND** temperature greater than 99.0° F or 37.2° C, if measured; **AND** arthralgia, arthritis, lymphadenopathy, or conjunctivitis **AND** lack of epidemiologic linkage to a laboratory-confirmed case of rubella; **AND** noncontributory or no serologic or virologic testing.

**Confirmed:** A case with or without symptoms who has laboratory evidence of rubella infection confirmed by one or more of the following laboratory tests: isolation of rubella virus; **OR** detection of rubella-virus specific nucleic acid by polymerase chain reaction; **OR** significant rise between acute- and convalescent-phase titers in serum rubella immunoglobulin G antibody level by any standard serologic assay; **OR** positive serologic test for rubella immunoglobulin M (IgM) antibody;

**OR**

An illness characterized by all of the following: acute onset of generalized maculopapular rash; **AND** temperature greater than 99.0°F or 37.2°C; **AND** arthralgia, arthritis, lymphadenopathy, or conjunctivitis; **AND** epidemiologic linkage to a laboratory-confirmed case of rubella.