

Congenital Rubella Syndrome Case Report

Date of Report:
Month Day Year

Date of last Evaluation of Infant:
Month Day Year

I PATIENT INFORMATION

Child's Name: Last _____ First _____ Middle _____		
Current Address: (County, State and Zip Code) _____		Age Congenital Rubella Syndrome Diagnosed: _____ Years _____ Months <input type="checkbox"/> Less than 1 Month <input type="checkbox"/> Unknown
Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day</small> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Year</small>	Birth Weight: _____ Grams _____ lbs. _____ oz. <input type="checkbox"/> Unknown	Gestational Age: _____ Weeks
Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown	Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other (specify) _____	Ethnicity: <input type="checkbox"/> Hispanic Origin <input type="checkbox"/> Not of Hispanic Origin <input type="checkbox"/> Unknown

II CLINICAL CHARACTERISTICS

<table style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="text-align: center;"><small>Yes No Unk.</small></td> </tr> <tr> <td>Cataracts</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Hearing Loss</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Mental Retardation</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Congenital Heart Disease</td> <td></td> </tr> <tr> <td> 1. Patent Ductus Arteriosus</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td> 2. Peripheral Pulmonic Stenosis</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td> 3. Congenital Heart Disease, Type Unknown</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td> 4. Other (Specify) _____</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>		<small>Yes No Unk.</small>	Cataracts	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hearing Loss	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Congenital Heart Disease		1. Patent Ductus Arteriosus	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	2. Peripheral Pulmonic Stenosis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	3. Congenital Heart Disease, Type Unknown	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	4. Other (Specify) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<table style="width: 100%;"> <tr> <td style="width: 50%;"></td> <td style="text-align: center;"><small>Yes No Unk.</small></td> </tr> <tr> <td>Meningoencephalitis</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Microcephaly</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Purpura</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Enlarged Spleen</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Enlarged Liver</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Long Bone Radiolucencies</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Congenital Glaucoma</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Pigmentary Retinopathy</td> <td style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></td> </tr> </table>		<small>Yes No Unk.</small>	Meningoencephalitis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Microcephaly	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Purpura	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Enlarged Spleen	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Enlarged Liver	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Long Bone Radiolucencies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Congenital Glaucoma	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pigmentary Retinopathy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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Other Abnormalities: Yes No Unknown If Yes, specify _____

Is Child Living? Yes No Unknown
 If No, Date of Death
Month Day Year

Causes of Death: (from death certificate)
 1. _____
 2. _____

If Child Died, Was Autopsy Performed?
 Yes No Unknown

Final Anatomical Diagnosis:

III MATERNAL HISTORY

Mother's Name: Last _____ First _____ Middle _____

Age at Delivery: _____ Years

Occupation at Time of Conception: _____
 Unemployed
 Unknown

Did Mother Attend Family Planning Clinic Prior to Conception? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of Previous Live Births: _____ <input type="checkbox"/> Unknown	Number of Previous Pregnancies: _____ <input type="checkbox"/> Unknown	Prenatal Care for this Pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of First Visit: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> <input type="checkbox"/> Unknown	Was Prenatal Care Obtained in: <input type="checkbox"/> Public Sector <input type="checkbox"/> Private sector <input type="checkbox"/> Unknown
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Rubella-Like Illness During Pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Month of Pregnancy: _____ <input type="checkbox"/> Unknown	Was Rubella Diagnosed by a Physician at Time of Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If not MD, by Whom? _____	Was Rubella Serologically Confirmed at Time of Illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Location of Exposure: Within the United States <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Outside the United States <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify country; also specify county and city, if known: _____ _____	If Location of Exposure is Unknown, did Mother Travel Outside the U.S. During the First Trimester of Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify country; also specify county and city, if known: _____ Date of Travel: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> <input type="checkbox"/> Unknown	Source of Exposure: Was the Mother Directly Exposed to a Known Rubella Case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, specify relationship: _____ Date of Exposure: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> <input type="checkbox"/> Unknown
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Number of Other Children Less than 18 Years of Age Living in Household During this Pregnancy: _____

Were Any of the Children Immunized with Rubella Vaccine?
 Yes No Unknown

Clinical Features of Maternal Illness: Rash..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Date of Onset: <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Year</td> <td colspan="4"></td> </tr> </table> Fever <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 Arthralgia/Arthritis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Other (specify) _____								Month	Day	Year					Was Mother Immunized with Rubella Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Date Vaccinated: <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Year</td> <td colspan="4"></td> </tr> </table> If Yes, Source of Information: <input type="checkbox"/> Physician <input type="checkbox"/> Mother Only <input type="checkbox"/> School <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Public Sector <input type="checkbox"/> Private Sector <input type="checkbox"/> Unknown								Month	Day	Year					Did the Mother Have Serological Testing for Rubella Immunity Prior to Exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Date: <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td style="text-align: center;">Year</td> <td colspan="4"></td> </tr> </table> If Yes, Interpretation of Test Results: <input type="checkbox"/> Susceptible <input type="checkbox"/> Immune <input type="checkbox"/> Unknown <small>(If more than one serologic test, include dates and results for each time tested.)</small>								Month	Day	Year				
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IV LABORATORY

Specimens for Viral Study Yes No

Mother Infant (Check one)	Type Specimen	Date Collected	Laboratory	Specific Test Methods Used (See below)*	Test Results
<input type="checkbox"/> <input type="checkbox"/>	_____	/ /			
<input type="checkbox"/> <input type="checkbox"/>	_____	/ /			
<input type="checkbox"/> <input type="checkbox"/>	_____	/ /			
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<input type="checkbox"/> <input type="checkbox"/>	_____	/ /			
<input type="checkbox"/> <input type="checkbox"/>	_____	/ /			

V APPRAISAL

<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Possible <input type="checkbox"/> Infection Only <input type="checkbox"/> Not CRS <input type="checkbox"/> Stillbirth <input type="checkbox"/> Unknown	<input type="checkbox"/> Indigenous to U.S. <input type="checkbox"/> Imported to U.S.	
Investigator's Name (print): _____	Telephone: _____	Date: _____
Physician Responsible for Child's Care: _____		Telephone: _____
Source of Report: <input type="checkbox"/> Private MD <input type="checkbox"/> Death Record <input type="checkbox"/> Birth Record <input type="checkbox"/> Laboratory <input type="checkbox"/> Hospital <input type="checkbox"/> Other		

LAB TEST METHODS

a) Viral Cultures	d) ELISA	g) Passive Hemagglutination (PHIA)
b) RIA	e) Hemagglutination Inhibition	h) Other (Specify) _____
c) IFA	f) Latex Agglutination	

*If antibody testing was performed, specify which Rubella-specific immunoglobulin antibody (IgM or IgG) was used.

DEFINITIONS

Clinical Case Definition An illness of newborns resulting from rubella infection in utero and characterized by signs and symptoms in the following categories: A Cataracts/congenital glaucoma, congenital heart disease (most commonly patent ductus arteriosus, peripheral pulmonary artery stenosis), loss of hearing, pigmentary retinopathy. B Purpura, splenomegaly, jaundice, microcephaly, mental retardation, meningoencephalitis, radiolucent bone disease.	Case Classification Possible: A case with some compatible findings but not meeting the criteria for a probable case. Probable*: A case that is not laboratory-confirmed and that has any two complications listed in A above, or one complication A and one from B. Confirmed: A clinically compatible case that is laboratory-confirmed. Infection Only: A case with laboratory evidence of infection, but without any clinical symptoms or signs. <small>*In probable cases, either or both of the eye-related findings (cataracts and congenital glaucoma) count as a single complication.</small>
Clinical Description The presence of any defects or laboratory data consistent with congenital rubella infection (as reported by a health professional).	Imported to U.S. A case which has its source of exposure outside the United States.
Laboratory Criteria for Diagnosis <ul style="list-style-type: none"> • Isolation of rubella virus, or • Demonstration of rubella-specific IgM antibody, or • An infant's rubella antibody level that persists above and beyond that expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of twofold dilution per month). 	Indigenous to U.S. A case which cannot be proved to be imported.