Congenital Rubella Syndrome (CRS) Surveillance Worksheet

NAME _____ (last) _____ (first) **ADDRESS (Street and No.)** _____ **Phone** _____ **Hospital Record No.** _____

This information will not be sent to CDC

REPORTING SOURCE TYPE NAME _____
☐ physician ☐ PH clinic **ADDRESS** _____
☐ nurse ☐ laboratory **ZIP CODE** _____
☐ hospital ☐ other clinic **PHONE** (__ __ __) __ __ __ __ __ __ __
☐ other source type _____

SUBJECT ADDRESS CITY _____
SUBJECT ADDRESS STATE _____
SUBJECT ADDRESS COUNTY _____
SUBJECT ADDRESS ZIP CODE __ __ __ __ __
LOCAL SUBJECT ID _____

CASE INFORMATION

Date of Birth __ __ __ __ __ __ __ __ (month day year) **Sex** M=male F=female ☐ **Ethnic Group** H=Hispanic/Latino N=Not Hispanic/Latino O=Other ____ U=Unknown ☐

Race ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Not asked ☐ Refused to answer ☐Other ☐ Unknown

Country of Birth _____ **Other Birth Place** _____ **Country of Usual Residence** _____

Age at Case Investigation _____ **Age Unit*** _____ **Reporting County** _____ **Reporting State** _____

Date Reported __ __ __ __ __ __ __ __ (month day year) **Date first Reported to PHD** __ __ __ __ __ __ __ __ (month day year) **National Reporting Jurisdiction** _____

Earliest Date Reported to County __ __ __ __ __ __ __ __ (mm/dd/yyyy) **Earliest Date Reported to State** __ __ __ __ __ __ __ __ (mm/dd/yyyy)

Case Class Status ☐Suspected ☐Confirmed ☐Unknown ☐Probable ☐Not a case **Case Investigation Start Date** __ __ __ __ __ __ __ __ (mm/dd/yyyy)

CASE INVESTIGATION STATUS CODE

	Approved		Deleted		Notified		Ready for review		Reviewed		Unknown
	Closed		In progress		Other (specify)_____		Rejected		Suspended		

CLINICAL CASE APPRAISAL ☐ confirmed ☐ probable ☐ possible ☐ infection ☐ not CRS ☐ stillbirth

CASE DETECTION METHOD

	Laboratory report		Prenatal testing		Provider reported		Self-referral
	Other _____		Prison entry screening		Routine physical		Unknown

Confirmation Date __ __ __ __ __ __ __ __ (month day year)

CASE CONFIRMATION METHOD

	Active surveillance		Lab diagnosis		No information given
	Case outbreak investigation		Lab reporting		Occupational disease surveillance
	Clinical diagnosis		Local/state specified		Other (specify) _____
	Epi-linked		Medical records review		Provider certified

INFANT HISTORY

Gestational Age (if case-patient <1 year of age) ☐☐ (weeks) **Birth State** _____ **Birth Weight** _____

Birth Weight Unit g=gram kg=kilogram oz=ounce lb=pound _____ **Age at Diagnosis** _____ **Age Unit* at Diagnosis** _____

Hospitalized? Y=yes N=no U=unknown ☐ **Hospital Admit Date** __ __ __ __ __ __ __ __ (month day year) **Hospital Discharge Date** __ __ __ __ __ __ __ __ (month day year)

Hospital Stay Duration 0 – 998 ☐☐☐ (999=unknown days) **Illness Onset Date** __ __ __ __ __ __ __ __ (month day year) **Illness End Date** __ __ __ __ __ __ __ __ (month day year)

Illness Duration _____ **Illness Duration Units*** _____ **Date of Diagnosis** __ __ __ __ __ __ __ __ (mm/dd/yyyy)

***UNITS** a=year d=day mo=month w=week UNK=unknown

INFANT TYPE OF COMPLICATIONS

	Y	N	U		Y	N	U		Y	N	U
Cataract				Hearing impairment				Patent ductus arteriosus			
Congenital glaucoma				Low platelets				Peripheral pulmonic stenosis			
Congenital heart disease				Meningoencephalitis				Pigmentary retinopathy			
Dermal erythropoiesis				Microencephaly				Purpura			
Developmental delay or Mental retardation				Neonatal jaundice				Radiolucent bone disease			
Enlarged liver				Other (specify)_____				Stenosis			
Enlarged spleen				Other congenital heart disease				Unknown			

[Y=yes N=no U=unknown]

INFANT DEATH INFORMATION

Date of last evaluation by healthcare provider? __ __ / __ __ / __ __ __ __ (month / day / year) | **Did infant die?** Y=yes N=no U=unknown ☐

At the time of pregnancy cessation, what was the age of the fetus? ☐☐ (weeks) | **Deceased Date** __ __ / __ __ / __ __ __ __ (month / day / year)

Death Certificate Primary Cause of Death _____ | **Death Certificate Secondary Cause of Death** _____

MATERNAL HISTORY

Mother's Birth Country _____ | **Mother's Country of Residence** _____ | **Mother's Age at Delivery** _____

Mother's Age at Delivery Units† _____ | **Length of time mother has been in the U.S.** _____ (years)

Did the mother attend a family planning clinic prior to conception? Y=yes N=no U=unknown ☐

The number of children less than 18 years of age living in household during this pregnancy? _____

Were any of the children living in the household immunized with rubella-containing vaccine? Y=yes N=no U=unknown ☐

The number of children <18 years of age immunized with the rubella vaccine? _____

†**UNITS** a=year d=day h=hour mo=month w=week min=minute s=second UNK=unknown

MATERNAL CLINICAL INFORMATION

Rash? Y=yes N=no U=unknown ☐ | **Rash Onset Date** __ __ / __ __ / __ __ __ __ (month / day / year) | **Rash Duration** ☐☐☐ (days)

Fever? Y=yes N=no U=unknown ☐ | **Fever Onset Date** __ __ / __ __ / __ __ __ __ (month / day / year) | **Fever Duration** ☐☐☐ (days)

Did the mother have lymphadenopathy during the time she was pregnant? Y=yes N=no U=unknown ☐

Did the mother have arthralgia/arthritis during time she was pregnant? Y=yes N=no U=unknown ☐

Did the mother have other clinical illnesses during the time she was pregnant? (specify) _____

Was prenatal care obtained for this pregnancy? Y=yes N=no U=unknown ☐

Date of first prenatal visit for this pregnancy? __ __ / __ __ / __ __ __ __ (month / day / year) | **Prenatal Care Provider** ☐public sector ☐private sector ☐unkown

Did the mother have serological testing prior to this pregnancy? Y=yes N=no U=unknown ☐

Mother's pre-pregnancy serological test date? __ __ / __ __ / __ __ __ __ (month / day / year) | **Pregnancy Outcome** ☐ Live-CRS ☐ Other ☐ Unknown

What was the mother's pre-pregnancy serological test interpretation? ☐ susceptible ☐ immune ☐ unknown

Was there a rubella-like illness during this pregnancy? Y=yes N=no U=unknown ☐

Pregnancy month that rubella-like symptoms appeared? ____ | **Previous U.S. birth(s)?** Y=yes N=no U=unknown

Was rubella physician-diagnosed? Y=yes N=no U=unknown ☐ | **U.S. Birth Dates** _____ _____ _____ (yyyy)

If rubella not diagnosed by physician, then by whom? _____ | **Number of births delivered in the US?** ☐☐

Was rubella lab testing performed with this pregnancy? Y=yes N=no U=unknown ☐ | **Number of previous pregnancies?** _____

Rubella serologically confirmed at time of illness? Y=yes N=no U=unknown ☐ | **Number of total live births?** ☐☐

EXPOSURE INFORMATION

Does the mother know where she might have been exposed to rubella? Y=yes N=no U=unknown ☐

Did the mother travel outside the U.S. during the first trimester of pregnancy? Y=yes N=no U=unknown ☐

International Destination(s) of Recent Travel	_____ _____	**Date Left for Travel** __ __ __ __ __ __ __ __ month day year	**Travel Return Date** __ __ __ __ __ __ __ __ month day year
	_____ _____	**Date Left for Travel** __ __ __ __ __ __ __ __ month day year	**Travel Return Date** __ __ __ __ __ __ __ __ month day year

Import Status – US-Acquired 1=import-linked case 2=imported virus case 3=endemic case 4=unknown source case 5=other ☐

Was the mother directly exposed to a confirmed case? Y=yes N=no U=unknown ☐ **Exposure Date** __ __ __ __ __ __ __ __ month day year

MOTHER'S RELATIONSHIP TO CONFIRMED RUBELLA CASE

☐	Brother	☐	Friend	☐	Mother	☐	Other	☐	Spouse
☐	Father	☐	Grandparent	☐	Neighbor	☐	Sister	☐	Unknown

Country of Exposure _____ **State or Province of Exposure** _____

County of Exposure _____ **City of Exposure** _____

CASE DISEASE IMPORTED CODE

☐	Indigenous	☐	In state, out of jurisdiction	☐	Unknown
☐	International	☐	Out of state	☐	Yes, imported, but not able to determine source state/country

Imported Country _____ **Imported State** _____ **Imported County** _____ **Imported City** _____

LABORATORY TESTING

VPD Lab Message Reference Laboratory _____ **VPD Lab Message Patient Identifier** _____

VPD Lab Message Specimen Identifier _____ **Lab testing done to confirm diagnosis?** Y=yes N=no U=unknown ☐

Was a specimen sent to CDC? Y=yes N=no U=unknown ☐ **Was case laboratory confirmed?** Y=yes N=no U=unknown ☐

Test Type	Specimen from: mother	infant	unknown	Date Specimen Collected (month day year)	Date Specimen Sent to CDC (month day year)	Date Specimen Analyzed (month day year)	Test Result	Test Result Quantitative	Result Units	Test Method	Specimen Source	Specimen Type	Performing Lab Type
IgM													
IgM (capture)													
IgG EIA (acute)													
IgG EIA (conv)													
culture													
PCR													
other													
unknown													
IFA													
Ab latex													
genotype													

TEST RESULTS CODES	SPECIMEN TYPE CODES	PERFORMING LABORATORY TYPE CODES	GENOTYPE CODES
P=positive N=negative X=not done E=pending I=Indeterminate NS=no significant rise in titer PS=significant rise in titer U=unknown	1=entire throat 6=entire eye 2=intervertebral space 7=pharyngeal 3=skin structure 8=other (specify) 4=mouth region 9=unknown 5=lens of eye 10=nasal cavity	1=CDC lab 5=public health lab 2=commercial lab 6=VPD testing lab 3=hospital lab 8=other (specify) 4=other clinical lab 9=unknown	1a 1F 2A 1B 1g 2B 1C 1H 2c 1D 1I other 1E 1J unknown

SPECIMEN SOURCE

2=blood 3=body fluid 4=BAL 8=cataract 9=CSF 11=DNA sample 15=NP aspirate 16=NP swab 17=NP washings 18=nucleic acid 19=oral fluid 20=oral swab 21=plasma 22=RNA sample 23=saliva 25=serum 38=urine 40=viral isolate 41=other 42=unknown

VACCINATION HISTORY

Vaccinated (was the mother immunized with a rubella vaccine)? Y=yes N=no U=unknown ☐

Number of vaccine doses the mother received on or after her first birthday? 0-6 99=unknown ☐☐ (doses)

Date of mother's last vaccine dose against this disease prior to illness onset? __ __ __ __ __ __ __ __ (mm/dd/yyyy)

Was mother vaccinated as recommended by ACIP? Y=yes N=no U=unknown ☐ **If "no" select reason below:**

Reason Not Vaccinated Per ACIP ☐☐

1 = religious exemption
2 = medical contraindication
3 = philosophical objection
4 = lab evidence of previous disease
5 = MD diagnosis of previous disease
6 = too young
7 = parent/patient refusal
8 = other ______________________
9 = unknown
10 = parent/patient forgot to vaccinate
11 = vaccine record incomplete/unavailable
12 = parent/patient report of previous disease
13 = parent/patient unaware of recommendation
14 = missed opportunity
15 = foreign visitor
16 = immigrant

Source of mother's vaccine information: 1=mother 2=physician 3=school 4=IIS 8=other ____________________ 9=unknown ☐

Vaccine Type	Vaccination Date (month day year)	Vaccine Manuf	Vaccine Lot Number	Vaccine Expiration Date (month day year)	National Drug Code	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	________	_______	___

VACCINE TYPE CODES

03=MMR (measles, mumps, rubella virus)
04=M/R (measles & rubella virus)
05=Measles (measles virus)
06=Rubella (rubella virus)
07=Mumps (mumps virus)
38=Rubella/mumps (rubella & mumps virus)
94=MMRV (measles, mumps, rubella, & varicella virus)
OTH=other
998=no vaccine administered
999=unknown

VACCINE MANUFACTURER CODES

MSD = Merck
OTH = other (specify)
UNK = unknown

VACCINE EVENT INFORMATION SOURCE CODES

00=new immunization record
01=historical information, source unidentified
02=historical information, other provider
05=historical information, other registry
06=historical information, birth certificate
07=historical information, school record
08=historical information, public agency
09=historical information, patient or parent recall
10=historical information, patient or parent written record
11=IIS record
OTH=other (specify)
UNK=unknown

CASE NOTIFICATION

CONDITION CODE	**10370**	**Immediate National Notifiable Condition** Y=yes N=no U=unknown ☐	**Legacy Case ID** _____
State Case ID _____	**Local Record ID** _____	**Jurisdiction Code** ___	**Binational Reporting Criteria** __ __ __ __ __ __ __
Date First Verbal Notification to CDC __ __ (month) __ __ (day) __ __ __ __ (year)		**Date Report First Electonically Submitted** __ __ (month) __ __ (day) __ __ __ __ (year)	
Date of Electronic Case Notification to CDC __ __ (month) __ __ (day) __ __ __ __ (year)		**MMWR Week** _____	**MMWR Year** _____
Notification Result Status ☐ Final results ☐ Record coming as correction ☐ Results cannot be obtained			
Person Reporting to CDC NAME _____ (first) _____ (last)		**Person Reporting to CDC Email** _____ @ _____ **Person Reporting to CDC Phone No.** (__ __ __) __ __ __ __ __ __ __	
Current Occupation _____		**Current Occupation Standardized** _____	
Current Industry _____		**Current Industry Standardized** _____	
COMMENTS			

CLINICAL CASE DEFINITION ₸

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 two 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.

OTHER CRITERIA

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.

[¶]**CSTE Position Statement 09-ID-61** at https://wwwn.cdc.gov/nndss/conditions/rubella-congenital-syndrome/case-definition/2010/