WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Rubella (German Measles)

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade: _____ Employer/School: _____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: _____ *Phone:* _____

*Birth date: __/__/____ Age: _____
*Gender: ☐Male ☐Female ☐Unk

*Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

*Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: _/_/_____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

REPORTING SOURCE

*Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _____ Address: _____ Phone: _____
Earliest date reported to county: _/_/_____ Earliest date reported to state: _/_/_____
Reporter Name: _____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____
Physician Address: _____ Phone Number: _____

Hospital

*Was patient hospitalized for this illness? ☐ **Y** ☐ **N** ☐ **U**
If yes: Hospital name: _____ Admit date: _/_/_____ Discharge date: _/_/_____

Condition Diagnosis date: __/__/____ *Illness onset date: __/__/____ Illness end date: _/_/_____

Did/does patient have:

Y N U
☐ ☐ ☐ Maculopapular rash If yes: Rash onset date: / /_____ Rash duration (in days): _____
☐ ☐ ☐ Fever
Highest measured temperature: _____° ☐ Fahrenheit ☐ Celsius

Symptoms

Y N U
☐ ☐ ☐ Arthralgia/Arthritis
☐ ☐ ☐ Lymphadenopathy
☐ ☐ ☐ Conjunctivitis

Complications

Y N U
☐ ☐ ☐ Arthralgia/Arthritis
☐ ☐ ☐ Encephalitis
☐ ☐ ☐ Thrombocytopenia
☐ ☐ ☐ Other complications (specify): _____

Did patient die from rubella or complications (including secondary infection) associated with rubella? ☐ **Y** ☐ **N** ☐ **U**
If yes, cause of death: _____

Clinical notes

*LABORATORY *(Please submit copies of all labs to DIDE)*

Y N U
☐ ☐ ☐ Was laboratory testing done for rubella?
☐ ☐ ☐ Were clinical specimens sent to CDC for genotyping? If yes: Date sent for genotyping: / /_____
Specimen type: ☐ Blood ☐ CSF ☐ Nasopharyngeal ☐ Throat ☐ Urine ☐ Other (specify): _____
☐ ☐ ☐ Was the rubella virus genotype sequenced?
If yes, genotype: ☐ 1a ☐ 1B ☐ 1C ☐ 1D ☐ 1E ☐ 1g ☐ 2A ☐ 2B ☐ 2c ☐ Unknown ☐ Other (specify): _____

LABORATORY TESTING

*Type of test	Date of collection	Source of specimen	Result value	Result	Lab
IgM (1st)					
IgM (2nd)					
IgG					
IgG – Acute					
IgG – Convalescent					
Viral Isolation					
PCR					
Other (specify)					
Other (specify)					
Other (specify)					

Lab notes

VACCINE INFORMATION

Did the patient receive a rubella-containing vaccine? ☐ **Y** ☐ **N** ☐ **U** If yes: Number of doses ON or AFTER first birthday? ____

If not vaccinated, what was the reason?

☐ Lab evidence of previous disease ☐ MD diagnosis of previous disease ☐ Medical contraindication ☐ Parental Refusal
☐ Philosophical objection ☐ Religious exemption ☐ Under age for vaccination ☐ Unknown ☐ Other (specify) _____________

*VACCINATION RECORD

Date received:_/_/________ Anatomical site: ___________________
Vaccine administered:________________ Vaccine ID: ___________
Manufacturer:__________________ Organization ID: ___________
Lot #:____________________ Expiration Date:_/_/_______

Given by: Last Name: ____________________________
First Name:_______________________ Provider ID: ____________
Organization Name: ____
Organization ID: ___________________

Date received:_/_/________ Anatomical site: ___________________
Vaccine administered:________________ Vaccine ID: ___________
Manufacturer:__________________ Organization ID: ___________
Lot #:____________________ Expiration Date:_/_/_______

Given by: Last Name: ____________________________
First Name:_______________________ Provider ID: ____________
Organization Name: ____
Organization ID: ___________________

Date received:_/_/________ Anatomical site: ___________________
Vaccine administered:________________ Vaccine ID: ___________
Manufacturer:__________________ Organization ID: ___________
Lot #:____________________ Expiration Date:_/_/_______

Given by: Last Name: ____________________________
First Name:_______________________ Provider ID: ____________
Organization Name: ____
Organization ID: ___________________

EPIDEMIOLOGIC

Y N U
☐ ☐ ☐ *Is this case epi-linked to a laboratory-confirmed case? If yes, case ID of epi-linked case: ___________

*Transmission Setting (where did this case acquire pertussis?):

☐ Athletics ☐ College ☐ Community ☐ Correctional facility
☐ Daycare ☐ Doctor's office ☐ Home ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Hospital ward ☐ International travel ☐ Military
☐ Place of worship ☐ School ☐ Work ☐ Other ☐ Unknown

Y N U
☐ ☐ ☐ * Is this case part of an outbreak of 3 or more cases? If yes, name of outbreak? __________________
Source of infection (i.e. Person ID, place, etc.): ______________________________
☐ ☐ ☐ Did rash onset occur 14-23 days upon entering the USA, following any travel or living outside the USA?
☐ ☐ ☐ *Is this case traceable (linked) to an international import?
☐ ☐ ☐ *Is this case epi-linked to another confirmed or probable case?
☐ ☐ ☐ Were age and setting verified?

Where was the disease acquired?
☐ Indigenous, within jurisdiction ☐ Out of country ☐ Out of jurisdiction, from another jurisdiction ☐ Out of state ☐ Unknown

Confirmation method:
☐ Active surveillance ☐ Case/Outbreak management ☐ Clinical diagnosis (not lab confirmed) ☐ Epidemiologically linked
☐ Lab confirmed ☐ Lab report ☐ Local/State specified ☐ Medical record review
☐ No information given ☐ Occupational disease surveillance ☐ Provider certified ☐ Other (specify):

MEDICAL HISTORY

Length of time in the US (in years)?_____Country of birth? _____

*If this is a female, is she pregnant? ☐ **Y** ☐ **N** ☐ **U** If yes, what is the expected delivery date?_/_/_____

Expected place of delivery:_____Number of weeks gestation at time of disease? _____

Trimester of gestation at time of disease? ☐ First ☐ Second ☐ Third ☐ Unknown

Note: Please follow-up on this case 2 weeks prior to delivery date to determine whether or not the baby has Congenital Rubella Syndrome (CRS) or Congenital Rubella Infection (CRI).

Is there documentation of previous rubella immunity testing? ☐ **Y** ☐ **N** ☐ **U**

If yes, result: ☐ Indeterminate ☐ Negative ☐ Positive ☐ Pending ☐ Unknown ☐ Not Done

Year of immunity testing:_____Age of woman at time of immunity testing (in years): _____

Did the woman ever have rubella disease prior to this pregnancy? ☐ **Y** ☐ **N** ☐ **U**

If yes, was previous rubella disease serologically confirmed by a physician? ☐ **Y** ☐ **N** ☐ **U**

Year of previous disease:_____Age of woman at time previous disease (in years): _____

What was the outcome of the current pregnancy? ☐ Live birth ☐ Not a live birth ☐ Unknown ☐ Other

If a live birth: ☐ Live birth with CRS ☐ Live birth with infection only ☐ Live birth without CRS or infection

If not a live birth: ☐ Elective termination ☐ Fetal death ☐ Spontaneous abortion ☐ Stillbirth

At the time of cessation of pregnancy, what was the age of the fetus (in weeks)? _____

Was autopsy/pathology study conducted? ☐ **Y** ☐ **N** ☐ **U**

If yes, result of autopsy/pathology study: _____

PUBLIC HEALTH ACTIONS/NOTES

☐ Public health action (education, prevention, intervention, etc.) done. If yes, specify date / /_____

☐ Lost to follow-up

Y=Yes N=No U=Unknown

*required surveillance indicator

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*Contact Tracing Sheet									
Name/Contact Information (including guardian information for minors)	Contact or source?	Date of Birth (mm/dd/yyyy)	Sex	Relation-ship to case?	Number of doses of rubella-containing vaccine?	Is this a case? (Y/N)	Rash onset date? **(mm/dd/yyyy)**	Immunity confirmed before/within 7 days after 1st exposure? (Y/N)	If no or unknown, action taken

Exposure period = 21 days before-14 days before rash onset

Infectious period = 7 days before – 7 days after rash onset

Number of contacts in any setting recommended PEP: