



Rubella

County _____

Case name (last, first) _____
 Birth date ___/___/___ Sex at birth F M Other Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____
 LHJ Case ID (optional) _____
 LHJ notification date ___/___/___
Classification Classification pending Confirmed
 Not reportable Probable Ruled out Suspect
 Investigation status
 In progress
 Complete
 Complete – not reportable to DOH
 Unable to complete Reason _____
 Investigation start date ___/___/___
 Investigation complete date ___/___/___
 Case complete date ___/___/___
 Outbreak related Yes No
 LHJ Cluster ID _____ Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ Years Months
Ethnicity Hispanic or Latino Not Hispanic or Latino Unk
Race (check all that apply) Unk Amer Ind/AK Native
 Asian Black/African Amer Native HI/other PI
 White Other _____
 Primary language _____
 Interpreter needed Yes No Unk
 Employed Yes No Unk Occupation _____
 Industry _____ Employer _____
 Work site _____ City _____
 Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College
 Graduate School Vocational Online Other
 School name _____
 School address _____
 City/State/County _____ Zip _____
 Phone number _____ Teacher's name _____

REPORT SOURCE

Initial report source _____
 LHJ _____
 Reporter organization _____
 Reporter name _____
 Reporter phone _____
 All reporting sources (list all that apply)

COMMUNICATIONS

Primary HCP name _____
 Phone _____
 OK to talk to patient (If Later, provide date)
 Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___
 Complete Partial Unable to reach
 Patient could not be interviewed
 Alternate contact Parent/Guardian Spouse/Partner
 Friend Other _____
 Name _____ Phone _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk
 Type of rubella Acquired Rubella Congenital Rubella Syndrome

Clinical Features

Y N Unk
 Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 Fever duration _____ days Fever onset date ___/___/___
 Rash (any) Onset ___/___/___ Duration _____ days
 Where did it first appear Head Chest Abdomen Upper extremities Lower extremities Back
 Other _____
 Rash progression: spread downward Distribution Generalized Localized Unk
 Arthralgia or arthritis
 Conjunctivitis
 Lymphadenopathy Location Postauricular Other cervical Generalized Unk
 Other _____
 Complications consistent with congenital rubella syndrome
 Coryza (runny nose) Onset ___/___/___
 Encephalitis or encephalomyelitis

- Pneumonia
 Diagnosed by X-Ray CT MRI Provider Only
 Result Positive Negative Indeterminate Not tested Other _____
- Thrombocytopenia
 Lowest platelet count _____ Value _____
- Any other complication _____
- Presumed secondary immune response
- MMR vaccination within 45 days preceding onset

Pregnancy

- Pregnancy status at time of symptom onset
- Pregnant (Estimated) delivery date ___/___/___ Weeks pregnant at any symptom onset _____
 OB name, phone, address _____
 Outcome of pregnancy Still pregnant Fetal death (miscarriage or stillbirth) Abortion
 Other _____
 Delivered – full term Delivered – preemie Delivered – Unk
 Delivery method Vaginal C-section Unk
 - Postpartum (Estimated) delivery date ___/___/___
 OB name, phone, address _____
 Outcome of pregnancy Fetal death (miscarriage or stillbirth) Abortion
 Other _____
 Delivered – full term Delivered – preemie Delivered – Unk
 Delivery method Vaginal C-section Unk
 - Neither pregnant nor postpartum Unk

Vaccination

Y N Unk

- Ever received a rubella containing vaccine Number of rubella doses prior to illness _____
 Number of doses before the 1st birthday _____
 Number of doses on or after 1st birthday _____
- Vaccine information available Yes No
- Date of vaccine administration ___/___/___ Vaccine administered (Type) _____
 Vaccine lot number _____ Administering provider _____
 Information source Washington Immunization Information System (WIIS) WIIS ID number _____
 Medical record Patient vaccination card Verbal only/no documentation Other state IIS
- Date of vaccine administration ___/___/___ Vaccine administered (Type) _____
 Vaccine lot number _____ Administering provider _____
 Information source Washington Immunization Information System (WIIS) WIIS ID number _____
 Medical record Patient vaccination card Verbal only/no documentation Other state IIS

Y N Unk

- Rubella vaccination up to date for age per ACIP
 Vaccine series not up to date reason
 Religious exemption Medical contraindication Philosophical exemption
 Laboratory confirmation of previous disease MD diagnosis of previous disease
 Underage for vaccine Parental refusal Other Unknown

Hospitalization

Y N Unk

- Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
- Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
- Still hospitalized As of ___/___/___
- Y N Unk**
- Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
- Autopsy performed
- Death certificate lists disease as a cause of death or a significant contributing condition
 Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)
 Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures 12-23 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Imported Indigenous (acquired in USA in reporting state)
 Case source Import-linked Imported virus Endemic Unk
 Out of state (acquired in USA but outside of reporting state)
 Case source (list all of the states visited in 21 days prior to rash onset) _____
 Date left ___/___/___ Date returned ___/___/___
 International (acquired outside USA)
 Case source (list all countries visited in 21 days prior to rash onset) _____
 Date left ___/___/___ Date returned ___/___/___
 Unk

Risk and Exposure Information**Y N Unk**

Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
 Contact with recent foreign arrival Country _____ Date(s) of contact ___/___/___
 Mother had rubella infection during pregnancy Describe _____
 Trimester 1st (1-12 weeks) 2nd (13-27 weeks) 3rd (28-42 weeks)
 Congregate living
 Barracks Corrections Long term care Dormitory Boarding school Camp Shelter
 Other _____
 Traceable within 2 generations to international import

Exposure and Transmission Summary**Y N Unk**

Epidemiologically linked to a lab positive case classified as confirmed
 Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk
 International travel related During entire exposure period During part of exposure period No international travel
 Suspected exposure type Person to person Health care associated Unk Other _____
 Describe _____
 Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____
 Describe _____
 Exposure Summary

Suspected transmission type (check all that apply) Person to person Health care associated Unk
 Other _____
 Describe _____
 Suspected transmission setting (check all that apply) Day care/Childcare School (not college) Doctor's office
 Hospital ward Hospital ER Hospital outpatient facility Home Work College Military
 Correctional facility Place of worship Laboratory Long term care facility Homeless/shelter
 International travel Out of state travel Transit Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____
 Describe _____

Public Health Issues**Y N Unk**

Have any contact with pregnant woman while contagious
 Evaluated immune status of close contacts Yes Date initiated ___/___/___
 Number of close contacts evaluated for immune status _____
 Number of susceptible contacts identified _____
 No, close contacts not evaluated
 No, case had no close contacts
 Unk

*If needed, enter detailed information in the Transmission Tracking Question Package***Public Health Interventions/Actions****Y N Unk**

Recommend droplet isolation if in a health care setting
 Isolate and exclude case from work, school, and all public places
 Exclude exposed susceptible persons from work/school for incubation period
 Letter sent Date ___/___/___ Batch date ___/___/___

TRANSMISSION TRACKING

Contagious period: 7 days prior to rash onset, 7 days after rash onset

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Day care School Airport Hotel/Motel/Hostel Transit Health care Home Work College
 Military Correctional facility Place of worship International travel Out of state travel LTCF
 Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	__/__/__	__/__/__	__/__/__	__/__/__
End Date	__/__/__	__/__/__	__/__/__	__/__/__
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

NOTES

LAB RESULTS

Lab report information

Lab report reviewed – LHJ

WDRS user-entered lab report note _____

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen

Specimen identifier/accession number _____

Specimen collection date __/__/__ **Specimen received date** __/__/__

WDRS specimen type _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result

WDRS test performed _____

WDRS test result, coded _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed Pending

Test result status Final results; Can only be changed with a corrected result

Preliminary results

Record coming over is a correction and thus replaces a final result

Results cannot be obtained for this observation

Specimen in lab; results pending

Result date __/__/__

Upload document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____