



# Rubella

County \_\_\_\_\_

Case name (last, first) \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age at symptom onset \_\_\_\_\_  Years  Months

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  Investigation in progress  Not reportable  Probable  Ruled out  Suspect

### Investigation status

Complete  Complete – not reportable to DOH  Unable to complete Reason \_\_\_\_\_  In progress

Dates: **Investigation start** \_\_\_/\_\_\_/\_\_\_ Investigation complete \_\_\_/\_\_\_/\_\_\_ Record complete \_\_\_/\_\_\_/\_\_\_ **Case complete** \_\_\_/\_\_\_/\_\_\_

## REPORT SOURCE

**Initial report source** \_\_\_\_\_ LHJ \_\_\_\_\_

Reporter organization \_\_\_\_\_

Reporter name \_\_\_\_\_ Reporter phone \_\_\_\_\_

All reporting sources (list all that apply) \_\_\_\_\_

## DEMOGRAPHICS

Sex at birth:  Female  Male  Other  Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

**Ethnicity**  Hispanic, Latino/a, Latinx  Non-Hispanic, Latino/a, Latinx  Patient declined to respond  Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

**Race**  Amer Ind/AK Native (**specify:**  Amer Ind **and/or**  AK Native)  Asian  Black or African American

Native HI/Pacific Islander (**specify:**  Native HI **and/or**  Pacific Islander)  White  Patient declined to respond  Unk

Additional race information:

Afghan  Afro-Caribbean  Arab  Asian Indian  Bamar/Burman/Burmese  Bangladeshi  Bhutanese

Central American  Cham  Chicano/a or Chicanx  Chinese  Congolese  Cuban  Dominican  Egyptian

Eritrean  Ethiopian  Fijian  Filipino  First Nations  Guamanian or Chamorro  Hmong/Mong

Indigenous-Latino/a or Indigenous-Latinx  Indonesian  Iranian  Iraqi  Japanese  Jordanian  Karen

Kenyan  Khmer/Cambodian  Korean  Kuwaiti  Lao  Lebanese  Malaysian  Marshallese  Mestizo

Mexican/Mexican American  Middle Eastern  Mien  Moroccan  Nepalese  North African  Oromo

Pakistani  Puerto Rican  Romanian/Rumanian  Russian  Samoan  Saudi Arabian  Somali

South African  South American  Syrian  Taiwanese  Thai  Tongan  Ugandan  Ukrainian

Vietnamese  Yemeni  Other: \_\_\_\_\_

What is your (your child's) preferred language? Check one:

Amharic  Arabic  Balochi/Baluchi  Burmese  Cantonese  Chinese (unspecified)  Chamorro  Chuukese

Dari  English  Farsi/Persian  Fijian  Filipino/Pilipino  French  German  Hindi  Hmong  Japanese

Karen  Khmer/Cambodian  Kinyarwanda  Korean  Kosraean  Lao  Mandarin  Marshallese  Mixteco

Nepali  Oromo  Panjabi/Punjabi  Pashto  Portuguese  Romanian/Rumanian  Russian  Samoan

Sign languages  Somali  Spanish/Castilian  Swahili/Kiswahili  Tagalog  Tamil  Telugu  Thai  Tigrinya

Ukrainian  Urdu  Vietnamese  Other language: \_\_\_\_\_  Patient declined to respond  Unknown

Interpreter needed  Yes  No  Unk

**EMPLOYMENT AND SCHOOL**

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 \_\_\_\_\_

**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 \_\_\_\_\_

Outbreak related  Yes  No LHJ Cluster ID \_\_\_\_\_ Cluster Name \_\_\_\_\_

**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 1<sup>st</sup> birthday \_\_\_\_\_  
Number of doses on or after 1<sup>st</sup> 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  1<sup>st</sup> (1-12 weeks)     2<sup>nd</sup> (13-27 weeks)     3<sup>rd</sup> (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  PendingTest 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 \_\_\_\_\_

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