

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

Is Child Living? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If No, Date of Death <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small>	Causes of Death: (from death certificate) 1. _____ 2. _____
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If Child Died, Was Autopsy Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Final Anatomical Diagnosis: _____ _____
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III MATERNAL HISTORY

Mother's Name: Last _____ First _____ Middle _____	Age at Delivery: _____ Years	Occupation at Time of Conception: <input type="checkbox"/> Unemployed <input type="checkbox"/> 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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Clinical Features of Maternal Illness:

Rash Yes No Unknown
 If Yes, Date of Onset:
 Month Day Year

Fever Yes No Unknown

Lymphadenopathy ... Yes No Unknown

Arthralgia/Arthritis: Yes No Unknown

Other (specify) _____

Was Mother Immunized with Rubella Vaccine?

Yes No Unknown

If Yes, Date Vaccinated:

 Month Day Year

If Yes, Source of Information:
 Physician Mother Only
 School Other (specify) _____
 Public Sector Private Sector
 Unknown

Did the Mother Have Serological Testing for Rubella Immunity Prior to Exposure?

Yes No Unknown

If Yes, Date:
 Month Day Year

If Yes, Interpretation of Test Results:
 Susceptible Immune Unknown
 (If more than one serologic test, include dates and results for each time tested.)

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"/>	_____	___/___/___	_____	_____	_____
<input type="checkbox"/> <input type="checkbox"/>	_____	___/___/___	_____	_____	_____
<input type="checkbox"/> <input type="checkbox"/>	_____	___/___/___	_____	_____	_____
<input type="checkbox"/> <input type="checkbox"/>	_____	___/___/___	_____	_____	_____
<input type="checkbox"/> <input type="checkbox"/>	_____	___/___/___	_____	_____	_____
<input type="checkbox"/> <input type="checkbox"/>	_____	___/___/___	_____	_____	_____

V APPRAISAL

Confirmed Probable Possible Infection Only Not CRS Stillbirth Unknown

Indigenous to U.S. Imported to U.S.

Investigator's Name (print): _____ Telephone: _____ Date: _____

Physician Responsible for Child's Care: _____ Telephone: _____

Source of Report:
 Private MD Death Record Birth Record Laboratory Hospital 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

<p>Clinical Case Definition</p> <p>An illness of newborns resulting from rubella infection in utero and characterized by signs and symptoms in the following categories:</p> <p>A Cataracts/congenital glaucoma, congenital heart disease (most commonly patent ductus arteriosus, peripheral pulmonary artery stenosis), loss of hearing, pigmentary retinopathy.</p> <p>B Purpura, splenomegaly, jaundice, microcephaly, mental retardation, meningoencephalitis, radiolucent bone disease.</p> <p>Clinical Description</p> <p>The presence of any defects or laboratory data consistent with congenital rubella infection (as reported by a health professional).</p> <p>Laboratory Criteria for Diagnosis</p> <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). 	<p>Case Classification</p> <p>Possible: A case with some compatible findings but not meeting the criteria for a probable case.</p> <p>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.</p> <p>Confirmed: A clinically compatible case that is laboratory-confirmed.</p> <p>Infection Only: A case with laboratory evidence of infection, but without any clinical symptoms or signs.</p> <p><small>*In probable cases, either or both of the eye-related findings (cataracts and congenital glaucoma) count as a single complication.</small></p> <p>Imported to U.S.</p> <p>A case which has its source of exposure outside the United States.</p> <p>Indigenous to U.S.</p> <p>A case which cannot be proved to be imported.</p>
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