

Rubella

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____

Referred to another state: _____

CASE

Last name: _____
First and middle name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____

Maiden name: _____ Suffix: _____

Gender: Female Male Other _____

Address line: _____

Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Zip: _____ City: _____

Marital status: Single Married Divorced Parent with partner Separated Widowed

State: _____ County: _____

Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian

Phone: (____) - ____ - ____ Type: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Long-term care resident: Yes No Unknown

Parent/Guardian name: _____

Facility name: _____

Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____

Last name: _____

Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown

First name: _____

Outbreak related: Yes No Unknown

Provider title: ARNP MD DO NP PA

Date of death: ____ / ____ / ____
 Case could not be found
 Case could not be interviewed
 Case refused interview
 Other – see notes

Event exception

Outbreak name: _____

Facility name: _____

Exposure setting: _____

Address line 1: _____

Epi-linked: Yes No Unk To whom: _____

Address line 2: _____

Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown

Zip code: _____ City: _____

State: _____ Country: _____

State: _____ County: _____

Phone : (____) - ____ - ____ Type: _____

Healthcare provider information

LABORATORY FINDINGS

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Organism: Rubella virus

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Organism: Rubella virus

Laboratory: _____	Accession #: _____	Collection date: ____/____/____
Date received: ____/____/____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____/____/____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: Rubella virus		

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____/____/____	Address: _____
Date worked to: ____/____/____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____/____/____	Phone: (____)____-____-____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____/____/____	Address: _____
Date worked to: ____/____/____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
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Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____/____/____	Discharge date: ____/____/____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

Symptoms	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____	Duration: _____ hrs/days	Date returned to normal activities: ____/____/____
	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____		
	Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____		
	Red eyes w/t drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____		
	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____		
	Thrombocytopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____		
	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset date: ____/____/____		
	Other complications:	Describe: _____			

Rash: Yes No Unk Onset date: ____ / ____ / ____ Duration: ____ hours/days

Fever continued w/t rash: Yes No Unk Rash spreading: Yes No Unk

Rash equally distributed: Yes No Unk Rash appeared at once: Yes No Unk

Lesions present: Yes No Unk Rash initial location: Arms Face Legs Trunk
 Inside mouth

_____ cm Heaviest lesion area: Arms Face Legs Trunk Scalp

of days for first lesion to crust: _____ days Areas present: Inside mouth Palms Soles

Lesions in same stage of development: Yes No Unk Severity: < 50 lesions 250 – 500 lesions
 50 – 249 lesions > 500 lesions

Rash characteristics: Burning Discrete lesions Numbness
 Confluent lesions Distinct sharp borders Painful
 Could be felt (papule) Dusky brown Peeling skin Reddish
 Could not be felt (macule) Marked itching Pustule Scaling/crusting

Koplik's spots: Yes No Unk

Healthcare provider visited: Yes No Unk Date(s) visited: ____ / ____ / ____ , ____ / ____ / ____

Swollen lymph nodes: Yes No Unk Location: _____

TREATMENT

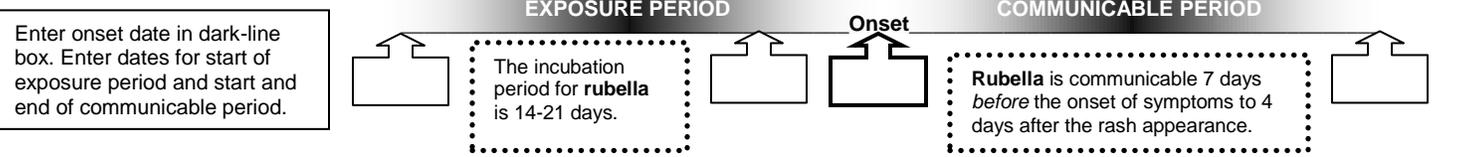
Antivirals prescribed: Yes No Unknown

Antiviral: _____ Date started: ____ / ____ / ____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antiviral: _____ Date started: ____ / ____ / ____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antiviral: _____ Date started: ____ / ____ / ____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____
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Therapeutic medications prescribed? Yes No Unk

List medications: _____

INFECTION TIMELINE



RISK FACTORS/TRAVEL

Vaccinated with MMR: Yes No Unknown

Date vaccinated: ____ / ____ / ____ Lot #: _____ Vaccine type: _____ Manufacturer: _____	Date vaccinated: ____ / ____ / ____ Lot #: _____ Vaccine type: _____ Manufacturer: _____	Date vaccinated: ____ / ____ / ____ Lot #: _____ Vaccine type: _____ Manufacturer: _____
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Number of vaccinations: _____

In the 21 days prior to the onset of symptoms did the case:

Traveled within Iowa? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk City in Iowa: _____	Departure date: ____ / ____ / ____	Return date: ____ / ____ / ____
Traveled within U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk State: _____ City: _____	Departure date: ____ / ____ / ____	Return date: ____ / ____ / ____
Traveled outside U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Country: _____	Departure date: ____ / ____ / ____	Return date: ____ / ____ / ____

Country outside the U.S.: _____

Born outside the U.S.? Yes No Unknown _____

Immunocompromised? Yes No Unknown

In the 7 days prior to the onset of rash through 4 days after the onset of rash did the case:

Use public transportation: Yes No Unk

Date(s) used:	Time(s) used:	Type:	Route:
/ /			
/ /			
/ /			

Visit a doctor's office, clinic or hospitals: Yes No Unknown

If Yes, complete the following table:

Facility name:	Address:	Zip code:	City:	State:	County:	Phone: ()- -	Type:	Date visited: / /	Time visited:	Provider name:	Title:

Visit a public places: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Phone	Date(s) visited	Time visited
		()- -	/ /	
		()- -	/ /	
		()- -	/ /	

Attend religious gatherings: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Attend family gatherings: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

Attend other gatherings: Yes No Unknown

If Yes, complete the following table:

Location name	Address/City/State/Zip	Date(s) attended	Time attended	Describe interactions:
		/ /		
		/ /		
		/ /		

