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

First and middle name: _____ Gender: ☐ Female ☐ Male ☐ Other _____

Maiden name: _____ Suffix: _____ Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /

Address line: _____ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed

Zip: _____ City: _____ Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian

State: _____ County: _____

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: / /

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death / /

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes

Outbreak name: _____

Exposure setting: _____

Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: _____

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

State: _____ Country: _____

Healthcare provider information

Last name: _____

First name: _____

Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____ City: _____

State: _____ County: _____

Phone : ( )- - Type: _____

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: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ 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: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms

Fever ☐ Yes ☐ No ☐ Unk Onset date: / / Duration: hrs/days Date returned to normal activities: / /

Cough ☐ Yes ☐ No ☐ Unk Onset date: / /

Runny nose ☐ Yes ☐ No ☐ Unk Onset date: / /

Red eyes w/t drainage ☐ Yes ☐ No ☐ Unk Onset date: / /

Diarrhea ☐ Yes ☐ No ☐ Unk Onset date: / /

Thrombocytopenia ☐ Yes ☐ No ☐ Unk Onset date: / /

Arthritis ☐ Yes ☐ No ☐ Unk Onset date: / /

Other symptoms

☐ Abdominal cramps
☐ Backache
☐ Chills
☐ Encephalitis
☐ Fatigue
☐ Fever
☐ Sore throat
☐ Vomiting
☐ Headache
☐ Joint pain
☐ Muscle pain
☐ Nausea
☐ Otitis media
☐ Photophobia

Other complications: [CA1] 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 ☐ 50 – 249 lesions ☐ 250 – 500 lesions ☐ > 500 lesions

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

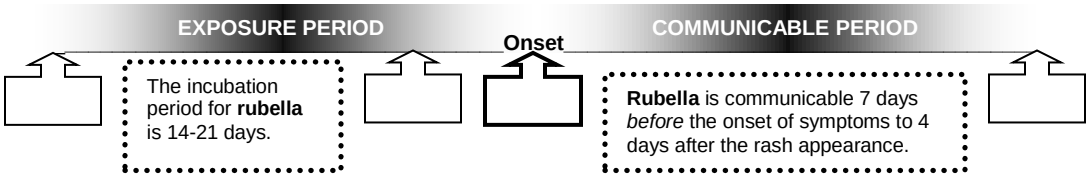
Antiviral:		Antiviral:		Antiviral:	
Date started:	/ /	Date started:	/ /	Date started:	/ /
Dose:		Dose:		Dose:	
Unit:	☐ mg ☐ ml ☐ IU	Unit:	☐ mg ☐ ml ☐ IU	Unit:	☐ mg ☐ ml ☐ IU
# of days:		# of days:		# of days:	
# of times a day:		# of times a day:		# of times a day:	
Route:		Route:		Route:	

Therapeutic medications prescribed? ☐ Yes ☐ No ☐ Unk

List medications: _____

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Vaccinated with MMR: ☐ Yes ☐ No ☐ Unknown

Date vaccinated:	/ /	Date vaccinated:	/ /	Date vaccinated:	/ /
Lot #:		Lot #:		Lot #:	
Vaccine type:		Vaccine type:		Vaccine type:	
Manufacturer:		Manufacturer:		Manufacturer:	

Number of vaccinations: ____ ☐ Laboratory confirmation of previous disease ☐ Religious exemption ☐ Unk

Reason case has not been vaccinated: ☐ Medical Contraindication ☐ Parental refusal ☐ Other:

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

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: _____ Departure date: / / Return date: / /

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: _____ City: _____ Departure date: / / Return date: / /

Traveled outside U.S? ☐ Yes ☐ No ☐ Unk Country: _____ Departure date: / / Return date: / /

Born outside the U.S.? ☐ Yes ☐ No ☐ Unknown Country outside the U.S.: _____

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: _____ Facility name: _____

Address: _____ Address: _____

Zip code: _____ City: _____ Zip code: _____ City: _____

State: _____ County: _____ State: _____ County: _____

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

Date visited: / / Time visited: _____ Date visited: / / Time visited: _____

Provider name: _____ Title: _____ 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:
		/ /		
		/ /		
		/ /		

Setting Acquired:

Child care	☐ Yes	☐ No	☐ Unk	Hospitalized	☐ Yes	☐ No	☐ Unk	Home	☐ Yes	☐ No	☐ Unk
Church	☐ Yes	☐ No	☐ Unk	International traveler	☐ Yes	☐ No	☐ Unk	School	☐ Yes	☐ No	☐ Unk
College	☐ Yes	☐ No	☐ Unk	Military	☐ Yes	☐ No	☐ Unk	Urgent care	☐ Yes	☐ No	☐ Unk
Correctional Facility	☐ Yes	☐ No	☐ Unk	Hospital ER/ Outpatient	☐ Yes	☐ No	☐ Unk	Work	☐ Yes	☐ No	☐ Unk
Doctors office	☐ Yes	☐ No	☐ Unk					Other			

Disease traced within 2 generations of known international import? ☐ Yes ☐ No ☐ Unk

CONTACTS

Number of people living in case's household: ____

Close contacts of the case (For more than one contact, print/copy additional contact pages.)

Last name: _____ Address: _____

First name: _____ City/State/Zip: _____ County: _____

DOB: __/__/____ Age: _____ Phone: _____ Type: _____

Gender: ☐ Female ☐ Male ☐ Other Symptoms present: ☐ Yes ☐ No ☐ Unk Onset date: __/__/____

If this contact has an onset date before this case then create a new case and event.

Symptoms:

Fever ☐	Onset date: __/__/____	Fatigue ☐	Same travel location(s):	☐ Yes	☐ No ☐ Unk
Cough ☐	Onset date: __/__/____	Headache ☐	Worked with case:	☐ Yes	☐ No ☐ Unk
Runny nose ☐	Onset date: __/__/____	Muscle pain ☐	From date:	/ /	
Red eyes w/t discharge ☐	Onset date: __/__/____	Nausea ☐	To date:	/ /	
Rash ☐	Onset date: __/__/____	Otitis media ☐	Similar exposure setting:	☐ Yes	☐ No ☐ Unk
Abdominal cramps ☐		Photophobia ☐	Contact exposure setting:	☐ Doctor's office	
Backache ☐		Pneumonia ☐		☐ Family gathering	
Chills ☐		Sore throat ☐		☐ Group meeting	
Encephalitis ☐		Vomiting ☐		☐ Public transportation	
				☐ Religious activity	

Vaccinated for Measles (MMR): ☐ Yes ☐ No ☐ Unk Number of vaccinations: Received within 3 days: ☐ Yes ☐ No ☐ Unk

Exposed to Measles: ☐ Yes ☐ No ☐ Unk Received IG within 6 days: ☐ Yes ☐ No ☐ Unk Date received: / / Dose: Unit: Route:

Tested for immunity: ☐ Yes ☐ No ☐ Unk Result: ☐ IgM+ ☐ IgM- ☐ IgG+ ☐ IgG-

Vaccinated for Smallpox: ☐ Yes ☐ No ☐ Unk Exposed to Smallpox: ☐ Yes ☐ No ☐ Unk Number of vaccinations: Received within 4 days: ☐ Yes ☐ No ☐ Unk

Vaccinated for Rubella: ☐ Yes ☐ No ☐ Unk Exposed to Rubella: ☐ Yes ☐ No ☐ Unk Number of vaccinations: Tested for immunity: ☐ Yes ☐ No ☐ Unk Result: ☐ IgM+ ☐ IgM- ☐ IgG+ ☐ IgG-

Date vaccinated: __/__/____	Date vaccinated: __/__/____	Date vaccinated: __/__/____
Lot #: _____	Lot #: _____	Lot #: _____
Vaccine type: _____	Vaccine type: _____	Vaccine type: _____
Manufacturer:	Manufacturer:	Manufacturer:

NOTES: _____