

Congenital Rubella Syndrome (CRS) Surveillance Worksheet

CRS MMG

GENERIC MMG

NAME	ADDRESS (Street and No.)	Phone	Hospital Record No.
(last) _____ (first) _____	_____	_____	_____

This information will not be sent to CDC

REPORTING SOURCE TYPE 48766-0 NAME _____ <input type="checkbox"/> physician <input type="checkbox"/> PH clinic ADDRESS _____ <input type="checkbox"/> nurse <input type="checkbox"/> laboratory ZIP CODE 52831-5 <input type="checkbox"/> hospital <input type="checkbox"/> other clinic PHONE (____) _____ <input type="checkbox"/> other source type _____	SUBJECT ADDRESS CITY PID-11.3 _____ SUBJECT ADDRESS STATE PID-11.4 _____ SUBJECT ADDRESS COUNTY PID-11.9 _____ SUBJECT ADDRESS ZIP CODE PID-11.5 _____ LOCAL SUBJECT ID PID-3 _____
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CASE INFORMATION

Date of Birth _____ PID-7 month day year	Sex M=male F=female <input type="checkbox"/> PID-8	Ethnic Group H=Hispanic/Latino N=Not Hispanic/Latino O=Other _____ U=Unknown <input type="checkbox"/> PID-22
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Race PID-10 can Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not asked <input type="checkbox"/> Refused to answer <input type="checkbox"/> Other 32624-9 <input type="checkbox"/> Unknown	Country of Birth 78746-5 _____	Other Birth Place 21842-0 _____
Country of Usual Residence 77983-5 _____		

Age at Case Investigation 77998-3 _____	Age Unit* OBX-6 for 77998-3 _____	Reporting County 77967-8 _____	Reporting State 77966-0 _____
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Date Reported _____ 77995-9 month day year	Date First Reported to PHD _____ 77970-2 month day year	National Reporting Jurisdiction _____ 77968-6
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Date First Reported to County 77972-8 _____ (mm/dd/yyyy)	Earliest Date Reported to State 77973-6 _____ (mm/dd/yyyy)
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Case Class Status 77990-0 <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Unknown <input type="checkbox"/> Probable <input type="checkbox"/> Not a case	Case Investi 77979-3 Start Date _____ (mm/dd/yyyy)
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CASE INVESTIGATION STATUS CODE	Approved	Deleted	Notified	Ready for review	Reviewed	Unknown
INV109						
	Closed	In progress	Other (specify) _____	Rejected	Suspended	

CLINICAL CASE APPRAISAL INV935 <input type="checkbox"/> confirmed <input type="checkbox"/> probable <input type="checkbox"/> possible <input type="checkbox"/> infection <input type="checkbox"/> not CRS <input type="checkbox"/> stillbirth
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CASE DETECTION METHOD INV159	Laboratory report	Prenatal testing	Provider reported	Self-referral	Confirmation Date _____ INV162 month day year
	Other _____	Prison entry screening	Routine physical	Unknown	

CASE CONFIRMATION METHOD	Active surveillance	Lab diagnosis	No information given
INV161			
	Case/outbreak investigation	Lab reporting	Occupational disease surveillance
	Clinical diagnosis	Local/state specified	Other (specify) _____
	Epi-linked	Medical records review	Provider certified

INFANT HISTORY

Gestational Age (if case-patient <1 year of age) 18185-9 <input type="checkbox"/> <input type="checkbox"/> (weeks)	Birth State 80910-3 _____	Birth Weight 8339-4 _____
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Birth Weight Unit OBX-6 for 8339-4 g=gram kg=kilogram oz=ounce lb=pound _____	Age at Diagnosis 63932-8 _____	Age Unit* at Diagnosis OBX-6 _____
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Hospitalized? 77974-4 Y=yes N=no U=unknown <input type="checkbox"/>	Hospital Admit Date _____ 8656-1 month day year	Hospital Discharge Date _____ 8649-6 month day year
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Hospital Stay Duration 0-998 999=unknown <input type="checkbox"/> <input type="checkbox"/> days 78033-8	Illness Onset Date _____ 11368-8 month day year	Illness End Date _____ 77976-9 month day year
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Illness Duration 77977-7 _____	Illness Duration Units* OBX-6 for 77977-7 _____	Date 77975-1 agnosis _____ (mm/dd/yyyy)
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*UNITS OBX-6 a=year d=day mo=month w=week UNK=unknown

INFANT TYPE OF COMPLICATIONS	Y N U			Y N U			Y N U					
	67187-5											
	Cataract				Hearing impairment				Patent ductus arteriosus			
	Congenital glaucoma				Low platelets				Peripheral pulmonic stenosis			
	Congenital heart disease				Meningoencephalitis				Pigmentary retinopathy			
	Dermal erythropeiosis				Microcephaly				Purpura			
	Developmental delay or Mental retardation				Neonatal jaundice				Radiolucent bone disease			
	Enlarged liver				Other (specify) _____				Stenosis			
	Enlarged spleen				Other congenital heart disease				Unknown			

[Y=yes N=no U=unknown] INV920

INFANT DEATH INFORMATION

Date of last evaluation by healthcare provider? ____ ____ ____ ____
month day year **Did infant die?** Y=yes N=no U=unknown

At the time of pregnancy cessation, what was the age of the fetus? ____ ____ (weeks) **Deceased Date** ____ ____ ____ ____
month day year

Death Certificate Primary Cause of Death **Death Certificate Secondary Cause of Death**

MATERNAL HISTORY

Mother's Birth Country **Mother's Country of Residence** **Mother's Age at Delivery**

Mother's Age at Delivery Units **Length of time mother has been in the U.S.** (years)

Did the mother attend a family planning clinic prior to conception? Y=yes N=no U=unknown

The number of children less than 18 years of age living in household during this pregnancy?

Were any of the children living in the household immunized with rubella-containing vaccine? Y=yes N=no U=unknown

The number of children <18 years of age immunized with the rubella vaccine?

†UNITS a=year d=day h=hour mo=month w=week min=minute s=second UNK=unknown

MATERNAL CLINICAL INFORMATION

Rash? Y=yes N=no U=unknown **Rash Onset Date** ____ ____ ____ ____
month day year **Rash Duration** ____ ____ (days)

Fever? Y=yes N=no U=unknown **Fever Onset Date** ____ ____ ____ ____
month day year **Fever Duration** ____ ____ (days)

Did the mother have lymphadenopathy during the time she was pregnant? Y=yes N=no U=unknown

Did the mother have arthralgia/arthritis during time she was pregnant? Y=yes N=no U=unknown

Did the mother have other clinical illnesses during the time she was pregnant? (specify) _____

Was prenatal care obtained for this pregnancy? Y=yes N=no U=unknown

Date of first prenatal visit for this pregnancy? ____ ____ ____ ____
month day year **Prenatal Care Provider** public sector private sector unk

Did the mother have serological testing prior to this pregnancy? Y=yes N=no U=unknown

Mother's pre-pregnancy serological test date? ____ ____ ____ ____
month day year **Pregnancy Outcome** Live-CRS Other Unknown

What was the mother's pre-pregnancy serological test interpretation? susceptible immune unknown

Was there a rubella-like illness during this pregnancy? Y=yes N=no U=unknown

Pregnancy month that rubella-like symptoms appeared? ____ **Previous U.S. birth(s)?** Y=yes N=no U=unknown

Was rubella physician-diagnosed? Y=yes N=no U=unknown **U.S. Birth Dates**

If rubella not diagnosed by physician, then by whom? **Number of births delivered in U.S.**

Was rubella lab testing performed with this pregnancy? Y=yes N=no U=unk **Number of previous pregnancies?**

Rubella serologically confirmed at time of illness? Y=yes N=no U=unknown **Number of total live births?** ____

EXPOSURE INFORMATION

Does the mother know where she might have been exposed to rubella? 85710-2 Y=yes N=no U=unknown

Did the mother travel outside the U.S. during the first trimester of pregnancy? 85709-4 Y=yes N=no U=unknown

International Destination(s) of Recent Travel <input type="checkbox"/> 82764-2	_____	Date Left for Travel <input type="checkbox"/> 82752-7 month day year	Travel Return Date <input type="checkbox"/> 55209-1 month day year
	_____	Date Left for Travel <input type="checkbox"/> 82752-7 month day year	Travel Return Date <input type="checkbox"/> 55209-1 month day year

Import Status – US-Acquired INV516 1=import-linked case 2=imported virus case 3=endemic case 4=unknown source case 5=other

Was the mother directly exposed to a confirmed case? 85708-6 Y=yes N=no U=unknown Exposure Date 85706-0 month day year

MOTHER'S RELATIONSHIP TO CONFIRMED RUBELLA CASE <input type="checkbox"/> 85707-8	Brother	Friend	Mother	Other	Spouse
	Father	Grandparent	Neighbor	Sister	Unknown

Country of Exposure 77984-3 State or Province of Exposure 77985-0

County of Exposure 77987-6 City of Exposure 77986-8

CASE DISEASE IMPORTED CODE <input type="checkbox"/> 77982-7	Indigenous	In state, out of jurisdiction	Unknown
	International	Out of state	Yes, imported, but not able to determine source state/country

Imported Country INV153 Imported State INV154 Imported County INV156 Imported City INV155

LABORATORY TESTING

VPD Lab Message Reference Laboratory LAB143 VPD Lab Message Patient Identifier LAB598

VPD Lab Message Specimen Identifier LAB125 Lab testing done to confirm diagnosis? LAB630 Y=yes N=no U=unknown

Was a specimen sent to CDC? 82314-6 Y=yes N=no U=unknown Was case laboratory confirmed? INV164 Y=yes N=no U=unknown

Test Type <input type="checkbox"/> INV290	Specimen from <input type="checkbox"/> 85793-8			Date Specimen Collected <input type="checkbox"/> 68963-8 month day year	Date Specimen Sent to CDC <input type="checkbox"/> 85930-6 month day year	Date Specimen Analyzed <input type="checkbox"/> 45375-3 month day year	Test Result <input type="checkbox"/> INV291	Test Result Quantitative <input type="checkbox"/> LAB628	Result Units <input type="checkbox"/> LAB115	Test Method <input type="checkbox"/> 85069-3	Specimen Source <input type="checkbox"/> 31208-2	Specimen Type <input type="checkbox"/> 66746-9	Performing Lab Type <input type="checkbox"/> 82771-7
	mother	infant	unknown										
IgM													
IgM (capture)													
IgG EIA (acute)													
IgG EIA (conv)													
culture													
PCR													
other													
unknown													
IFA													
Ab latex													
genotype													

TEST RESULTS CODES	SPECIMEN TYPE CODES	PERFORMING LABORATORY TYPE CODES	GENOTYPE CODES
P=positive N=negative X=not done E=pending I=Indeterminate NS=no significant rise in titer PS=significant rise in titer U=unknown	1=entire throat 6=entire eye 2=intervertebral space 7=pharyngeal 3=skin structure 8=other (specify) 4=mouth region 9=unknown 5=lens of eye 10=nasal cavity	1=CDC lab 5=public health lab 2=commercial lab 6=VPD testing lab 3=hospital lab 8=other (specify) 4=other clinical lab 9=unknown	85690-6 1a 1F 2A 1B 1g 2B 1C 1H 2c 1D 1I other 1E 1J unknown
SPECIMEN SOURCE			
2=blood 3=body fluid 4=BAL 8=cataract 9=CSF 11=DNA sample 15=NP aspirate 16=NP swab 17=NP washings 18=nucleic acid 19=oral fluid 20=oral swab 21=plasma 22=RNA sample 23=saliva 25=serum 38=urine 40=viral isolate 41=other 42=unknown			

VACCINATION HISTORY

Vaccinated (was the mother immunized with a rubella vaccine)? 85702-9 Y=yes N=no U=unknown

Number of vaccine doses the mother received on or after her first birthday? VAC129 0-6 99=unknown (doses)

Date of mother's last vaccine dose against this disease prior to illness onset VAC142 ____ ____ ____ ____ (mm/dd/yyyy)

Was mother vaccinated as recommended by ACIP? VAC148 Y=yes N=no U=unknown **If "no" select reason below:**

Reason Not Vaccinated Per ACIP VAC149

1 = religious exemption	6 = too young	11 = vaccine record incomplete/unavailable	16 = immigrant
2 = medical contraindication	7 = parent/patient refusal	12 = parent/patient report of previous disease	
3 = philosophical objection	8 = other _____	13 = parent/patient unaware of recommendation	<input type="checkbox"/>
4 = lab evidence of previous disease	9 = unknown	14 = missed opportunity	
5 = MD diagnosis of previous disease	10 = parent/patient forgot to vaccinate	15 = foreign visitor	

Source of mother's vaccine information? 48766-0 1=mother 2=physician 3=school 4=IIS 8=other _____ 9=unknown

Vaccine Type	Vaccination Date	Vaccine Manuf	Vaccine Lot Number	Vaccine Expiration Date	National Drug Code	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number
<input checked="" type="checkbox"/> 30956-7	<input checked="" type="checkbox"/> 30952-6 month day year	<input checked="" type="checkbox"/> 30957-5	<input checked="" type="checkbox"/> 30959-1	<input checked="" type="checkbox"/> VAC109 month day year	<input checked="" type="checkbox"/> VAC153	<input checked="" type="checkbox"/> VAC102	<input checked="" type="checkbox"/> VAC147	<input checked="" type="checkbox"/> 30973-2
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

VACCINE TYPE CODES	VACCINE MANUFACTURER CODES	VACCINE EVENT INFORMATION SOURCE CODES
03=MMR (measles, mumps, rubella virus) 04=M/R (measles & rubella virus) 05=Measles (measles virus) OTH =other 06=Rubella (rubella virus) 998 =no vaccine administered 07=Mumps (mumps virus) 999 =unknown 38=Rubella/mumps (rubella & mumps virus) 94=MMRV (measles, mumps, rubella, & varicella virus)	MSD = Merck OTH = other (specify) UNK = unknown	00=new immunization record 01=historical information, source unspecified 02=historical information, other provider 11=IIS record 05=historical information, other registry OTH=other (specify) 06=historical information, birth certificate UNK=unknown 07=historical information, school record 08=historical information, public agency 09=historical information, patient or parent recall 10=historical information, patient or parent written record

CASE NOTIFICATION

CONDITION CODE OBR-31	10370	Immediate National Notifiable Condition Y=yes N=no U=unknown <input type="checkbox"/>	Legacy Case ID 77997-5
State Case ID 77993-4	Local Record ID OBR-3	Jurisdiction Code 77969-4	Binational Reporting Criteria 77988-4
Date First Verbal Notification to CDC 77994-2 month day year		Date Report First Electronically Submitted OBR-7 month day year	
Date of Electronic Case Notification to CDC OBR-22 month day year		MMWR Week 77991-8	MMWR Year 77992-6
Notification Result Status OBR-25 <input type="checkbox"/> Final results <input type="checkbox"/> Record coming as correction <input type="checkbox"/> Results cannot be obtained			
Person Reporting to CDC NAME 74549-7 (first) _____ (last) _____		Person Reporting to CDC Email 74547-1 @ _____	
		Person Reporting to CDC Phone No. 74548-9 (____) _____	
Current Occupation 85658-3		Current Occupation Standardized 85659-1	
Current Industry 85078-4		Current Industry Standardized 85657-5	
COMMENTS 77999-1			

CLINICAL CASE DEFINITION [†]

SUSPECTED

An infant that does not meet the criteria for a probable or confirmed case but who has one of more of the following clinical findings:

- cataracts or congenital glaucoma,
- congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis),
- hearing impairment,
- pigmentary retinopathy,
- purpura,
- hepatosplenomegaly,
- jaundice,
- microcephaly,
- developmental delay,
- meningoencephalitis, OR
- radiolucent bone disease

PROBABLE

An infant without an alternative etiology that does not have laboratory confirmation of rubella infection but has at least two of the following[§]:

- cataracts or congenital glaucoma,[§]
- congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis),
- hearing impairment, OR
- pigmentary retinopathy;

OR

An infant without an alternative etiology that does not have laboratory confirmation of rubella infection but has at least one or more of the following:

- cataracts or congenital glaucoma,[§]
- congenital heart disease (most commonly patent ductus arteriosus or peripheral pulmonary artery stenosis),
- hearing impairment, OR
- pigmentary retinopathy

AND one or more of the following:

- purpura,
- hepatosplenomegaly,
- jaundice,
- microcephaly,
- developmental delay,
- meningoencephalitis, OR
- radiolucent bone disease

CONFIRMED

An infant with at least one symptom (listed above) that is clinically consistent with congenital rubella syndrome; and laboratory evidence of congenital rubella infection as demonstrated by:

- isolation of rubella virus,
OR
- detection of rubella-specific immunoglobulin M (IgM) antibody,
OR
- infant rubella antibody level that persists at a higher level and for a longer period than expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of a twofold dilution per month),
OR
- a specimen that is PCR positive for rubella virus.

OTHER CRITERIA

Infection only:

An infant without any clinical symptoms or signs but with laboratory evidence of infection as demonstrated by:

- isolation of rubella virus,
OR
- detection of rubella-specific immunoglobulin M (IgM) antibody,
OR
- infant rubella antibody level that persists at a higher level and for a longer period than expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of a twofold dilution per month),
OR
- a specimen that is PCR positive for rubella virus.

§In probable cases, either or both of the eye-related findings (cataracts and congenital glaucoma) count as a single complication. In cases classified as infection only, if any compatible signs or symptoms (e.g., hearing loss) are identified later, the case is reclassified as confirmed.

†CSTE Position Statement 09-ID-61 at <https://www.cdc.gov/nndss/conditions/rubella-congenital-syndrome/case-definition/2010/>