

SURVEILLANCE OF CONGENITAL RUBELLA SYNDROME (CRS) – CASE INVESTIGATION FORM

EPIDEMIOLOGY UNIT, MINISTRY OF HEALTH

The MOH should do the investigation personally. Necessary data should be obtained from the hospital by reference to the BHT/Physician or from the diagnosis card. Early investigation and return are essential.

Week ending of notification	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>d d m m y y</small>	Serial No: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Please write the Serial No given in the Infectious Disease Register (ID Register) in the MOH Office
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A. PARTICULARS OF PATIENT (Please tick (✓) the appropriate box where applicable)

1. Name of patient (BLOCK LETTERS)

2. Residential address:

3. Date of Birth: / / (dd/mm/yyyy)

4. Age <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <small>y y / m m</small>	5. Sex <input type="checkbox"/> 1. male <input type="checkbox"/> 2. female <input type="checkbox"/> 3. not known	6. Ethnic group <input type="checkbox"/> 1. Sinhalese <input type="checkbox"/> 2. Tamil <input type="checkbox"/> 3. Moor <input type="checkbox"/> 4. others <input type="checkbox"/> 5. not known	7. Occupation <input type="text"/> <input type="text"/>	8. DPDHS Division (district) <input type="text"/> <input type="text"/>	9. MOH area <input type="text"/> <input type="text"/>
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B. PRESENT ILLNESS/OUTCOME

<p>10. Date of onset of symptoms: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>d d m m y y</small></p> <p>11. Where did the patient first seek medical advice? <input type="checkbox"/> 1. government hospital <input type="checkbox"/> 2. private hospital <input type="checkbox"/> 3. private practitioner <input type="checkbox"/> 4. Ayurvedic institution (public/private) <input type="checkbox"/> 5. other (specify) </p>	<p>12. Was patient admitted to hospital? <input type="checkbox"/> 1. yes → to Q. 13 <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known } skip to Q. 21</p> <p>13. If yes, date of admission: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>d d m m y y</small></p> <p>14. Name of hospital:</p> <p>15. Ward:</p> <p>16. BHT no:</p>	<p>17. Date of discharge/transfer or death: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>d d m m y y</small></p> <p>18. If transferred, name of hospital</p> <p>19. Was patient transferred from some other hospital? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no</p> <p>20. If "yes", where was the patient transferred from?</p> <p>21. Outcome of the case <input type="checkbox"/> 1. cured <input type="checkbox"/> 3. transferred <input type="checkbox"/> 2. died <input type="checkbox"/> 4. not known</p>
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C. CLINICAL DATA

Case definition: an illness usually manifesting in infancy due to rubella infection in-utero and characterized by any of the following symptoms or signs

1. cataracts/congenital glaucoma, pigmentary retinopathy
2. congenital heart disease
3. loss of hearing
4. purpura, splenomegaly, jaundice
5. meningoencephalitis, microcephaly, mental retardation
6. radiolucent bone disease
7. laboratory data consistent with CRS

<p>22. Symptoms and signs</p> <p><input type="checkbox"/> 1. cataract / congenital glaucoma</p> <p><input type="checkbox"/> 2. hearing impairment</p> <p><input type="checkbox"/> 3. pigmentary retinopathies</p> <p><input type="checkbox"/> 4. congenital heart disease →</p> <p style="margin-left: 40px;"> <input type="checkbox"/> a. atrial septal defect <input type="checkbox"/> b. ventricular septal defect <input type="checkbox"/> c. patent ductus arteriosus <input type="checkbox"/> d. coarctation of the aorta <input type="checkbox"/> e. peripheral pulmonic stenosis <input type="checkbox"/> f. other (specify) </p>	<p>23. Associated symptoms</p> <p><input type="checkbox"/> 1. purpura</p> <p><input type="checkbox"/> 2. splenomegaly</p> <p><input type="checkbox"/> 3. jaundice</p> <p><input type="checkbox"/> 4. microcephaly</p> <p><input type="checkbox"/> 5. mental retardation</p> <p><input type="checkbox"/> 6. meningoencephalitis</p> <p><input type="checkbox"/> 7. radiolucent bone disease</p> <p><input type="checkbox"/> 8. other (specify)</p>
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Compatible with the case definition:

1. Yes

2. No

D. LABORATORY FINDINGS

24. Was blood taken for serological investigations? 1. yes 2. no 3. not known

25. If yes:

Investigation	Date of collection of specimen (dd/mm/yy)	Laboratory MRI/ other govt./ private/ not known	Results (mark NA if test results are not available and PP if pending)
1. rubella haemagglutination inhibition test			
2. maternal IgG persisting >6/52 in infant			
3. rubella specific IgM			
4. virus isolation			

E. MATERNAL HISTORY	F. MOTHER'S IMMUNIZATION HISTORY	G. CONTACT HISTORY
<p>26. Age of mother at time of delivery: <input type="checkbox"/><input type="checkbox"/> years</p> <p>27. Did the mother have a rubella-like illness during the present pregnancy? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p> <p>28. If yes, period of gestation at the time of illness <input type="checkbox"/><input type="checkbox"/> in weeks <input type="checkbox"/> not known</p> <p>29. Which of the following symptoms and signs were present? <input type="checkbox"/> 1. fever <input type="checkbox"/> 2. rash <input type="checkbox"/> 3. lymphadenopathy <input type="checkbox"/> 4. conjunctivitis <input type="checkbox"/> 5. arthritis/arthralgia <input type="checkbox"/> 6. others (specify) </p> <p>30. Was rubella serologically confirmed? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p>	<p>31. Was the mother immunized for rubella? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p> <p>32. If yes, date of vaccination: <input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/><input type="checkbox"/> d d m m y y <input type="checkbox"/> not known</p> <p>33. Type of vaccine used: <input type="checkbox"/> 1. Rubella <input type="checkbox"/> 3. MR <input type="checkbox"/> 2. MMR <input type="checkbox"/> 4. Not known</p> <p>34. Place of vaccination <input type="checkbox"/> 1. MOH clinic <input type="checkbox"/> 2. school <input type="checkbox"/> 3. government hospital <input type="checkbox"/> 4. private dispensary/surgery <input type="checkbox"/> 5. private hospital <input type="checkbox"/> 6. other (specify) <input type="checkbox"/> 7. not known</p> <p>35. If not immunized, reason: <input type="checkbox"/> 1. medical contraindication <input type="checkbox"/> 2. unaware of the need for vaccination <input type="checkbox"/> 3. non-availability of vaccine <input type="checkbox"/> 4. no faith in the vaccine <input type="checkbox"/> 5. others (specify) <input type="checkbox"/> 6. not known</p>	<p>36. Was the mother in contact with a known or suspected case of rubella during the index pregnancy? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p> <p>37. If yes, period of gestation in weeks: <input type="checkbox"/><input type="checkbox"/> <input type="checkbox"/> not known</p> <p style="text-align: center;">FOR OFFICE USE Time between immunization and development of maternal infection <input type="checkbox"/><input type="checkbox"/> yrs <input type="checkbox"/><input type="checkbox"/> months</p>

38. Remarks:

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Signature: Name:.....

Date: Designation:

Please return to:
Epidemiologist, Epidemiology Unit, 231, De Saram Place, Colombo 10
 email: epidunit@slt.net.lk Tel: 011-2695112 / 2681548 Fax: 011-2696583

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Final classification	
Laboratory confirmed	<input type="checkbox"/>
Epidemiologically confirmed	<input type="checkbox"/>
Clinically confirmed	<input type="checkbox"/>