Congenital Rubella Syndrome (CRS) Case Investigation Form

Health Protection Agency
Male', Maldives

Reporting Institution:

Instructions:

1. This form should be completed for each clinically suspected case of CRS.
2. All cases must have samples collected and sent to IGMH laboratory for testing.
3. Please put dates in DD/MM/YYYY format

Case ID:_____ **Date of notification :**_____/_____/_____

Date of investigation:_____/_____/_____**Date of reporting :**_____/_____/_____

Case identification

1. Patient ID Card Number (Foreigners passport number):

2. Date of Birth: _/____/_____ **4. Age:**_____(yy/mm) 5**. Sex:** ☐ Male **or** ☐ Female

3. Name of patient: **6. Contact Number:**

Address: **Atoll:** **Island:**

7. Place infant delivered: **8. Name of mother:**

Clinical Information

Group A (Please complete all)	**Group B** (Please complete all)
▪ Congenital Heart Disease: ☐Yes ☐No ☐UK	▪ Purpura : ☐Yes ☐No ☐UK
▪ Cataract: ☐Yes ☐No ☐UK	▪ Microcephaly : ☐Yes ☐No ☐UK
▪ Congenital glaucoma: ☐Yes ☐No ☐UK	▪ Meningoencephalitis : ☐Yes ☐No ☐UK
▪ Pigmentary retinopathy: ☐Yes ☐No ☐UK	▪ Jaundice : ☐Yes ☐No ☐UK
▪ Hearing impairment: ☐Yes ☐No ☐UK	▪ Splenomegaly : ☐Yes ☐No ☐UK
	▪ Developmental delay : ☐Yes ☐No ☐UK
	▪ Radiolucent bone disease: ☐Yes ☐No ☐UK

▪ Other abnormalities: ☐Yes ☐No, if Yes please describe:

Maternal history/Antenatal care

▪ Mother age : _____years	▪ No of previous pregnancies:_____
▪ Vaccinated against rubella: ☐Yes ☐No ☐UK	▪ If yes, date: _/____/_____
▪ Maculopapular rash: ☐Yes ☐No ☐UK	▪ If yes, date of onset:____/____/_____
▪ Wes rubella laboratory confirmed: ☐ Yes ☐No ☐UK	▪ If yes, when (date): _/____/_____
▪ Exposed during pregnancy to any ☐ Yes ☐No ☐UK	▪ If yes, when (date): _/____/_____

person of any age with maculopapular rash	Where_____

Vaccination History

MMR vaccination status: ☐Yes ☐No If YES Date: _/___/_____ if NO reason:_____

Measles vaccination status ☐Yes ☐No If YES Date: _/___/_____ if NO reason:_____

Laboratory test of infant/child

Specimen collected: ☐Yes ☐No ☐UK

If yes type of specimen: ☐ Serum, ☐ Throat Swab, ☐ Urine, ☐ Cerebrospinal fluid, ☐ Other

Date of specimen collection: _/___/_____; Date of specimen sent to IGMH Lab: _/____/_____

Date lab received sample: _/____/_____; Date lab reported result: _/____/_____;

Rubella IgM : ☐ Not tested, ☐ Positive, ☐ Negative, ☐ Equivocal, ☐ In process

Sustained Rubella IgG Level* : ☐ IgG not tested, ☐ Yes, ☐ No, ☐ In process

*(sustained IgG level on at least 2 occasions between 6 and 12 months of age)

Rubella virus isolation : ☐ Not tested, ☐ Positive, ☐ Negative, ☐ In process

Rubella PCR: ☐ Not done, ☐ Positive, ☐ Negative, ☐ In process, Genotype_____

Final classification:

- CRS, ☐ Discarded, If discarded, please specify_____

Case classification as ☐ Laboratory confirmed, ☐ Epidemiologically linked, ☐ Clinically confirmed,

Classification by origin: ☐ Endemic, ☐ Imported, ☐ Import-related, ☐ Unknown

Date of final classification: _/____/_____;

Name of the investigator:	Position:
Date : _/____/_____;	Signature: