Please fax to: 604.707.2515
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655 West 12th Ave, Vancouver, BC, V5Z 4R4

CONGENITAL RUBELLA REPORTING FORM

REPORTING INFORMATION

Case Identifier:

Month of Reporting:

Province:

Today's Date:

Please complete the following sections for the case identified above. Confidentiality of information will be assured.

CASE DEFINITION FOR CONGENITAL RUBELLA SYNDROME (CRS) OR INFECTION

CRS/Confirmed case: Includes live and stillborn children. Any *clinically compatible defect(s)* and one or more of the following *(laboratory confirmation)*:

1. Detection of rubella virus.
2. Detection of rubella-specific IgM (in the absence of recent immunization with rubella-containing vaccine).
3. Persistence of rubella-specific IgG longer than expected from passive transfer of maternal antibody.

CRS/Clinical case: *Clinically compatible defects* without laboratory confirmation, in the absence of any other known cause.

Clinically compatible defects means that the case has, at least, any two complications listed in (A), or one complication from (A) and one from (B).

(A) Cataracts or congenital glaucoma (either or both, count as one), congenital heart disease, sensorineural hearing loss, pigmentary retinopathy.
(B) Purpura, splenomegaly, jaundice, microcephaly, mental retardation, meningoencephalitis, radiolucent bone disease, progressive conditions occurring during childhood or adulthood, such as diabetes and progressive panencephalitis, and any other conditions possibly caused by rubella virus.

N.B.: If any of the following laboratory findings exists, then the case cannot be classified as a "CRS/Clinical case":

1. Rubella antibody titre absent in the infant.
2. Rubella antibody titre absent in the mother.
3. Rubella antibody titre declines in the infant consistent with the normal decline after birth of passively transferred maternal antibody.

Congenital Rubella Infection: A case with no defects present but laboratory confirmation of infection.

SECTION 1 — DEMOGRAPHIC INFORMATION

1.1 Patient Identifier: _____

1.2 Date of birth: __ __ __ __/__ __ __ __/__ __ __ __
DD MM YYYY

1.3 Sex: Male ☐ Female ☐

SECTION 2 — CLINICAL FEATURES

2.1 **General**	Yes	No	Unknown	
Intrauterine growth retardation	☐	☐	☐	
Premature birth	☐	☐	☐	
In utero death	☐	☐	☐	
Infant death	☐	☐	☐	If **yes**, date of death: __ __ __ __/__ __ __ __/__ __ __ __ (DD / MM / YYYY)
Ocular:				
Congenital cataract	☐	☐	☐	
Congenital glaucoma	☐	☐	☐	
Pigmentary retinopathy	☐	☐	☐	
Microphthalmia	☐	☐	☐	
Auditory:				
Sensorineural hearing loss	☐	☐	☐	
Cardiovascular				
Patent ductus arteriosus	☐	☐	☐	
Pulmonary stenosis	☐	☐	☐	
Ventricular/atrial septal defects	☐	☐	☐	
Myocarditis	☐	☐	☐	
Neurological				
Meningoencephalitis	☐	☐	☐	
Microcephaly	☐	☐	☐	
Mental retardation	☐	☐	☐	
Miscellaneous				
Splenomegaly	☐	☐	☐	
Jaundice	☐	☐	☐	
Purpura	☐	☐	☐	
Radiolucent bone disease	☐	☐	☐	
Progressive conditions				
Diabetes	☐	☐	☐	
Progressive panencephalitis	☐	☐	☐	
Other abnormality(ies) (e.g. generalized lymphadenopathy)	☐	☐	☐	

If **yes**, specify: _____

_____

SECTION 3 — LABORATORY INVESTIGATION OF CHILD

3.1 Isolation of rubella virus: Yes ☐ No ☐ Unknown ☐ Not done ☐

If **yes**, site: _____ Date collected: __ __ __ __/__ __ __ __/__ __ __ __ (DD / MM / YYYY)

3.2 Presence of rubella-specific IgM: Yes ☐ No ☐ Unknown ☐ Not done ☐

If **yes**, type of test: _____ Result: _____ Date collected: __ __ __ __/__ __ __ __/__ __ __ __ (DD / MM / YYYY)

3.3 Presence of persisting rubella-specific IgG antibodies: Yes ☐ No ☐ Unknown ☐ Not done ☐

If **yes**, type of test: _____ Result: _____ Date collected: __ __ __ __/__ __ __ __/__ __ __ __ (DD / MM / YYYY)

If **yes**, type of test: _____ Result : _____ Date collected: __ __ __ __/__ __ __ __/__ __ __ __ (DD / MM / YYYY)

SECTION 4 — HISTORY OF MOTHER

4.1 Age at delivery: ☐

4.2 Ethnicity:

Aboriginal Canadian-born ☐

Non-aboriginal Canadian-born ☐

Foreign-born ☐ Country of birth: _____ Year of arrival in Canada: _____

Unknown ☐

4.3 Number of previous pregnancies:

Gravida ☐ Para ☐

4.4 Immunization with rubella-containing vaccine: Yes ☐ No ☐ Unknown ☐

If **known**, name(s) of vaccine(s):	Date(s) of immunization(s): (DD / MM / YYYY)	Place (city, prov., country)
_____	__ __ __ __/__ __ __ __/__ __ __ __	_____
_____	__ __ __ __/__ __ __ __/__ __ __ __	_____
_____	__ __ __ __/__ __ __ __/__ __ __ __	_____

4.5 Routine rubella IgG testing before or during current/previous pregnancy(ies): Yes ☐ No ☐ Unknown ☐
(prenatal screening)

If **yes**, type of test most recently done: Result: _____ Date of test: _____ __ __ __ __/__ __ __ __/__ __ __ __ (DD / MM / YYYY)

4.6 Contact with a person with rubella or a rash during pregnancy: Yes ☐ No ☐ Unknown ☐

4.7 Rubella-like illness or any rash during pregnancy: Yes ☐ No ☐ Unknown ☐

If **yes**, week or month of pregnancy: ☐ weeks or ☐ months

4.8 Rubella outbreak in mother's area of residence during pregnancy: Yes ☐ No ☐ Unknown ☐

SECTION 4 — HISTORY OF MOTHER (cont'd)

4.9 Laboratory confirmation of rubella infection during pregnancy? Yes ☐ No ☐ Method _____
Check all that apply or are appropriate:

Isolation of rubella virus: Yes ☐ No ☐ Unknown ☐

Presence of rubella-specific IgM: Yes ☐ No ☐ Unknown ☐

Four-fold rise of rubella-specific IgG antibodies (tests performed simultaneously?): Yes ☐ No ☐ Unknown ☐

SECTION 5 — REPORTING PHYSICIAN

First name Surname

Address

City Province Postal code

( ) Telephone number

( ) Fax number

Date form completed: __ __ __ /__ __ __ __ /__ __ __ __ __
DD MM YYYY

Thank you for completing this form.