

Rubella Surveillance Worksheet

APPENDIX 16-3

Name (Last, First)			Hospital Record No.		
Address (Street and No.)		City PID-11.3	County PID-11.9	Zip PID-11.5	Phone
Reporting Physician/Nurse/Hospital/Clinic/Lab 48766-0		Address			Phone

..... DETACH HERE and transmit only lower portion if sent to CDC

Rubella MMG

Rubella Surveillance Worksheet

Generic MMG

County PID-11.9	State PID-11.4	Zip PID-11.5	Country of Birth 78746-5
Birth Date PID-7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Age 77998-3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unk = 999	Age Type OBX-6 for 77998-3 <input type="checkbox"/> 0 = 0-120 years <input type="checkbox"/> 3 = 0-28 days <input type="checkbox"/> 1 = 0-11 months <input type="checkbox"/> 9 = Age unknown <input type="checkbox"/> 2 = 0-52 weeks	Ethnicity PID-22 <input type="checkbox"/> H = Hispanic <input type="checkbox"/> N = Not Hispanic <input type="checkbox"/> U = Unknown
Race PID-10 <input type="checkbox"/> N = Native Amer/Alaskan Native <input type="checkbox"/> W = White <input type="checkbox"/> A = Asian/Pacific Islander <input type="checkbox"/> O = Other 32624-9 <input type="checkbox"/> B = African American <input type="checkbox"/> U = Unknown		Sex PID-8 <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female <input type="checkbox"/> U = Unknown	
Event Date <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Event Type <input type="checkbox"/> 1 = Onset 11368-8 <input type="checkbox"/> 4 = Repo 77972-8 buntly <input type="checkbox"/> 2 = Diagnosis 77975-1 <input type="checkbox"/> 5 = Repo 77973-6 ate or <input type="checkbox"/> 3 = Lab Report Date MMWR Report Date <input type="checkbox"/> 9 = Unknown	Outbreak Associated <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unk = 999	Reported 77995-9 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year
Imported 77982-7 <input type="checkbox"/> 1 = Indigenous <input type="checkbox"/> 2 = International <input type="checkbox"/> 3 = Out of State <input type="checkbox"/> 9 = Unknown		Report Status 77990-0 <input type="checkbox"/> 1 = Confirmed <input type="checkbox"/> 2 = Probable <input type="checkbox"/> 3 = Suspect <input type="checkbox"/> 9 = Unknown	

CLINICAL DATA	Any Rash? 56831-1 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV919	Rash Onset 81268-5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Rash Duration 81269-3 <input type="checkbox"/> <input type="checkbox"/> 0 - 30 Days <input type="checkbox"/> 99 = Unknown	COMPLICATIONS	Encephalitis? 67187-5 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV920	Arthralgia/Arthritis? 67187-5 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV920	
	Fever? 56831-1 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV919	If Recorded, Highest Measured Temp. 81265-1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 36.0 - 110.0 Degrees 999.9 = Unknown OBX-6 for 81265-1			Thrombocytopenia? 67187-5 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV920	Death? 77978-5 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Other Complications 67187-5 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV920
	Arthralgia/Arthritis? 56831-1 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV919	Lymphadenopathy? 56831-1 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV919	Conjunctivitis? 56831-1 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown INV919		Hospitalized? 77974-4 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Days Hospitalized 8656-1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	If Yes, Please Specify:

LABORATORY	Was Laboratory Testing for Rubella Done? LAB630 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	VACCINE HISTORY	Vaccinated? (Received rubella-containing vaccine?) VAC 126 <input type="checkbox"/> Y = Yes N = No U = Unknown				
	Date IgM INV290 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year		Result INV291 P = Positive E = Pending N = Negative X = Not Done I = Indeterminate U = Unknown				
	Date IgG Acute INV290 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year		Date IgG Convalescent INV290 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year				
	Specimen Taken 68963-8 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year		Specimen Taken 68963-8 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year				
Result INV291 P = Significant Rise in IgG N = No Significant Rise in IgG I = Indeterminate E = Pending X = Not Done U = Unknown	Other Lab Result INV291 P = Positive N = Negative I = Indeterminate X = Not Done E = Pending Un = Unknown	Specify Other Lab Method: INV290	Vaccination Date 30952-6 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Vaccine Dose 30973-2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Vaccine Type 30956-7 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Manuf. 30957-5 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Lot Number 30959-1 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year
Number of doses received ON or AFTER 1 st birthday VAC129 <input type="checkbox"/>		If Not Vaccinated, What Was the Reason? VAC149 <input type="checkbox"/> 1 = Religious Exemption 6 = Under Age for Vaccination 2 = Medical Contraindication 7 = Parental Refusal 3 = Philosophical Objection 8 = Other 4 = Lab Evidence of Previous Disease 9 = Unknown 5 = MD Diagnosis of Previous Disease					

EPIDEMIOLOGIC	Date First Reported to a Health Department 77970-2 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Date Case Investigation Started 77979-3 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Month Day Year	Outbreak Related? 77980-1 <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	
	Transmission Setting (Where did the patient acquire rubella?) 81267-7 <input type="checkbox"/> 1 = Day Care 6 = Hospital 11 = Military 2 = School 7 = Home 12 = Correctional 3 = Doctor's Office 8 = Work 13 = Church 4 = Hospital Ward 9 = Unknown 14 = International Travel 5 = Hospital ER 10 = College 15 = Other		Source of Exposure For Current Case (Enter State ID 77993-4 if source was an in-state case; enter Country 77984-3 if source was out of U.S.; enter State 77985-0 if source was out-of-state)	
	If Other, Specify Transmission Setting: 81267-7		Epi-Linked to Another Confirmed or Probable Case? INV217 <input type="checkbox"/>	
Were Age and Setting Verified? (Is age appropriate for Setting) 85700-3 <input type="checkbox"/> Y = Yes N = No U = Unknown				

