Rubella

ORPHEUS ID

☐ confirmed
☐ presumptive
☐ suspect
☐ no case

Name _____ County_____
LAST, first, initials (a.k.a.)

Address _____
Street City Zip

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

E-mail _____

ALTERNATE CONTACT

Name _____ Phone(s)_____
LAST, first, initials home (H), work (W), cell (C), message (M)

Special housing
- ☐ Nursing home/ Asst Living
- ☐ Homeless
- ☐ Prison/jail
- ☐ Foster home
- ☐ Hospital
- ☐ Nursing home
- ☐ Other institution
- ☐ Drug treatment/ shelter
- ☐ Women's shelter
- ☐ YES house
- ☐ Homeless shelter
- ☐ Job Corps
- ☐ Treatment center
- ☐ Chemawa Indian School
- ☐ Pacific Univ.
- ☐ No address on file

DEMOGRAPHICS

DOB ____/____/____ if DOB unknown, AGE _____ Sex ☐ Female ☐ Male Preg ☐ Y ☐ N ☐ UNK
m d y

Language _____ Country of birth _____ ☐ refugee

Worksites/school/day care center _____ Occupation/grade_____

Amer Indian/ Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis First Nation
- ☐ Indigenous Mexican Central American South American

HISPANIC or Latino/a
- ☐ Hispanic or Latino/a Central American
- ☐ Hispanic or Latino/a Mexican
- ☐ Hispanic or Latino/a South American
- ☐ Other Hispanic or Latino/a

ASIAN
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian/ Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Micronesian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Black or African American
- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Middle Eastern Northern African
- ☐ Northern African
- ☐ Middle Eastern

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

Other Categories
- ☐ Other (please list) _____
- ☐ Don't know/Unknown
- ☐ Don't want to answer/ Decline

_____

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
_____
_____
_____

Reporter Type (circle one)
PMD Lab ELR
MDx Lab Fax
UC Lab Phn
ER Lab Other
HCP 2nd Prov
ICP

Reporter Name/Phone
_____
_____
_____

☐ Ok to contact patient (only list once)
Local epi_name_____
Date report received by LHD ____/____/____LHD completion date ____/____/____

CASE'S NAME _____

BASIS OF DIAGNOSIS - RUBELLA

CLINICAL DATA

PRODOME ☐ yes ☐ no ☐ unk
if yes, ONSET DATE (first s/s) ____/____/___

Diagnosis date ____/____/_____

Check all that apply

y	n	u	r	
☐	☐	☐	☐	symptomatic
☐	☐	☐	☐	prodome
☐	☐	☐	☐	headache symptom onset ____/____/____
☐	☐	☐	☐	coryza
☐	☐	☐	☐	conjunctivitis
☐	☐	☐	☐	malaise
☐	☐	☐	☐	fever - date noted ____/____/____
				maximum temp. recorded _____

RASH ☐ yes ☐ no ☐ unk

if yes, ONSET DATE (first s/s) ____/____/___
Duration _____ days

Number locations in order of rash appearance

____ face/neck/forehead _____trunk
____ extremities _____ other (specify)

Type of rash

☐ maculopapular ☐ vesicular
☐ petechial ☐ _____

Pruitic ☐ yes ☐ no
Were antibiotics used in the 7 days before rash onset?
☐ yes ☐ no ☐ unk

If yes, specify

OTHER CLINICAL FINDINGS

☐ lymphadenopathy
- ☐ cervical
- ☐ postauricular
- ☐ suboccipital
- ☐ _____

☐ arthritis/arthralgic
☐ hemorrhagic signs
☐ pneumonia
☐ encephalitis
☐ _____

HOSPITALIZATION

Deceased: ☐ yes ☐ no
if yes, date of death ____/____/____

Cause: _____
☐ related to disease ☐ unrelated to disease ☐ unk

Hospitalized: ☐ yes ☐ no ☐ unk
Hospital Name _____
admit date ____/____/____ ☐ ICU
discharge date ____/____/____

Hospital Name _____
admit date ____/____/____ ☐ ICU
discharge date ____/____/____

LABORATORY DATA

Laboratory Name _____
Collection date ____/____/____
Result date ____/____/____

Virus isolation
pos neg unk not done

☐	☐	☐	☐	throat swab ____/____/____
☐	☐	☐	☐	Urine ____/____/____

PCR
pos neg unk not done

☐	☐	☐	☐	throat swab ____/____/____
☐	☐	☐	☐	urine ____/____/____

Serology
pos neg unk not done

☐	☐	☐	☐	IgM specimen taken ____/____/____
☐	☐	☐	☐	IgG Acute specimen taken ____/____/____
☐	☐	☐	☐	IgG Convalescent specimen taken ____/____/____

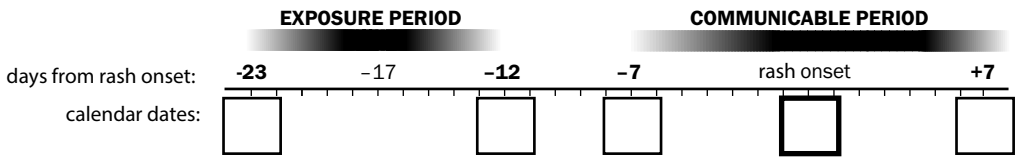
Tests for other agents
☐ yes ☐ no ☐ unk
if yes, specify and give details, dates, type of test, results etc).

☐ measles
☐ strep
☐ mononucleosis
☐ parovirus
☐ _____
☐ _____

CASE'S NAME

INFECTION TIMELINE

Enter onset date of rash in heavy box. Count forwards and backwards to figure probable exposure and communicable periods.



Interviewed ☐ yes ☐ no Interview date(s) _____ Interviewed by _____

Who ☐ patient ☐provider ☐ parent ☐ other

Reason not interviewed (choose one)

☐ not indicated ☐ unable to reach ☐ out of jursdiction ☐ deceased
☐ refused ☐ physician interview ☐ medical record review

POSSIBLE SOURCES OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case was already epi-linked.

RISKS

y n u r

☐ ☐ ☐ ☐ Travel outside the home area
When _____
*Where*_____
☐ ☐ ☐ ☐ contact of suspect case
☐ ☐ ☐ ☐ prior vaccination
☐ ☐ ☐ ☐ places where exposed (check boxes to right)
☐ ☐ ☐ ☐ other risk, specify in notes

Places where exposed

☐ daycare
☐ school
☐ doctor's office
☐ hospital ward
☐ hospital ER
☐ hosp.outpatient clinic
☐ home
☐ work
☐ college
☐ military
☐ correctional facility
☐ place of worship
☐ international travel
☐ other
☐ unknown

FOLLOW-UP

y n u r

☐ ☐ ☐ ☐ contact with infants
☐ ☐ ☐ ☐ contact with pregnant women
☐ ☐ ☐ ☐ contact with immunocompromised patients

Settings where the case may have exposed others during infectious period

☐ daycare
☐ school
☐ doctor's office
☐ hospital ward
☐ hospital ER
☐ hosp.outpatient clinic
☐ >1 setting outside household
☐ work
☐ unknown
☐ college
☐ military
☐ correctional facility
☐ place of worship
☐ international travel
☐ other
☐ no documented spread

EPI-LINKAGE

y n u

☐ ☐ ☐ associated with known outbreak
☐ ☐ ☐ close contact of confirmed or presumptive case

Nature

☐ coworker ☐ daycare
☐ friend ☐ household
☐ infant ☐ unborn baby

☐ ☐ ☐ has case been reported

Epi-link ☐ household ☐ sporadic ☐ outbreak

Exposure type

☐ single ☐ multiple ☐ unknown

Exposure date and time ___/___/___ _____

Outbreak ID_____

Is the patient aware of anyone with a similar illness? Provide contact information and other relevant details.

CASE'S NAME _____

IMMUNIZATION HISTORY

Up to date for measles ☐ yes ☐ no ☐ unk

Vaccine	*Date*	*Source choose one:* ALERT / Provider / Verbal (Shot card) / Verbal (not verified)
_____	___/____/____	_____
_____	___/____/____	_____
_____	___/____/____	_____
_____	___/____/____	_____
_____	___/____/____	_____

If you have access to ALERT, please print the vaccination history and staple to this form.

Vaccinated: ☐ yes ☐ no ☐ unk
if not vaccinated, why not?
☐ Religious exemption
☐ Medical contraindication
☐ Philosophical exemption
☐ Previous culture/MD confirmed
☐ Parental/patient refusal
☐ Too young
_____
☐ Forgot
☐ Inconvenience
☐ Too expensive
_____
☐ Concurrent illness
☐ Parent/patient unaware
☐ Vaccination records incomplete (unavailable)
☐ Other

CONTACT MANAGEMENT

Add additional sheets as necessary	Contact 1	Contact 2
Name (First, middle, last, no initials please)		
Phone number		
Address (street, city)		
Address, (county, zip)		
Date of birth/ age mm/dd/yyyy or years of age	___/___/___	___/___/___
High risk	☐ Yes ☐No	☐ Yes ☐No
Sex	☐ Male ☐Female	☐ Male ☐Female
Pregnant	☐ Yes ☐No *if yes*, due date ___/___/___	☐ Yes ☐No *if yes*, due date ___/___/__
Relation to case (coworker, daycare, friend, household, infant, unborn baby)		
Occupation		
Sick	☐ Yes ☐No *if yes*, onset date ___/___/__	☐ Yes ☐No *if yes*, onset date ___/___/__
First exposure / Last exposure	First exposure ___/___/___ Last exposure ___/___/___	First exposure ___/___/___ Last exposure ___/___/___
Location of exposure		
Education provided?	☐ Yes ☐No *if yes*, date ___/___/___	☐ Yes ☐No *if yes*, date ___/___/___
MMR 1 mm/dd/yyyy	___/___/___	___/___/___
MMR 2 mm/dd/yyyy	___/___/___	___/___/___
History of prior disease (circle one)	☐ Yes ☐No ☐ Unk	☐ Yes ☐No ☐ Unk
Up-to-date for disease (circle one)	☐ Yes ☐No ☐ Unk	☐ Yes ☐No ☐ Unk
Vax count		
Specimen (date), test type, result		
Lab name		

ADMINISTRATION

JULY 2019

Case report sent to OHA on ___/___/___ ` **Investigation sent to OHA on** ___/___/___

Completed by _____ **Date** _____ **Phone** _____