NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division in the National Health Laboratory Service

Patient initials ☐☐
Patient date of birth ☐☐/☐☐/☐☐☐☐

National Institute for Communicable Diseases
Congenital Rubella Syndrome Case Report form

Part A: Notifier's details

Notifier's name and surname: _____ Facility where form completed: _____ Role: Doctor ☐ IPC nurse ☐ Other ☐ state: _____	Address of health facility:_____ District of health facility:_____ Province of health facility_____ Notifier cellphone: _____ Notifier's email: _____ Notifier's landline office: _____ Date of submission of this CRF (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐

Part B: Patient demographic and clinical details (see page 2)

Patient's names and surname: _____ Facility where CRS diagnosed: _____ Medical record number: _____	Sex: Male ☐ Female ☐ Other ☐ Date of patient's birth: (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Age at diagnosis: days: ☐☐ months: ☐☐ year(s): ☐☐ Race group of infant: Black ☐ Indian ☐ Colored ☐ White ☐ Unknown ☐ Other ☐

Part C: Mother/guardian's demographic and clinical details (see page 3)

Mother's names and surname: _____ Facility where infant born: _____ Mother's medical record number at ante-natal clinic (if available): _____	Mother's residential address:_____ District of residence:_____ Province of residence_____ Date of birth: (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ Mother's cellphone: _____ Mother's cellphone (alternate): _____

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Part B: Patient's Clinical details

B1. *Where was the patient born?* Health care facility? ☐ Home ☐ Other ☐

Place name_____ Place address_____

District_____ Province_____

B2. *Pregnancy outcome:* Live birth Yes ☐ No ☐ Unknown ☐ Premature delivery Yes ☐ No ☐ Unknown ☐ Termination Yes ☐ No ☐ Unknown ☐ Stillbirth Yes ☐ No ☐ Unknown ☐ Other Yes ☐ No ☐ Unknown ☐ state: _____

B3. *Gestation age at birth in weeks:* _____

B4. *Birth weight (grams):*_____

B5. *Did a health care worker suspect CRS at birth?* Yes ☐ No ☐ Unknown ☐

B6. How was the d*iagnosis of CRS made? (mark all that apply):* Clinical presentation Yes ☐ No ☐ Unknown ☐ Laboratory test results Yes ☐ No ☐ Unknown ☐ Autopsy Yes ☐ No ☐ Unknown ☐ Other Yes ☐ No ☐ Unknown ☐ State:_____

B7. *Which of the following signs and symptoms of CRS were present at the time of diagnosis?*

	Y	N	U
Glaucoma	☐	☐	☐
Pigmentary retinopathy	☐	☐	☐
Hearing impairment or deafness	☐	☐	☐
Cataracts	☐	☐	☐
If yes, unilateral?	☐	☐	☐
Or bilateral	☐	☐	☐
Congenital heart disease	☐	☐	☐
If yes, describe:			

	Y	N	U
Microcephaly	☐	☐	☐
Purpura	☐	☐	☐
Hepatosplenomegaly	☐	☐	☐
Meningoencephalitis	☐	☐	☐
Radiolucent bone disease	☐	☐	☐
Jaundice, within 24 hours of birth	☐	☐	☐
Mental retardation	☐	☐	☐
Developmental delay	☐	☐	☐

B8. *Provide details of the laboratory tests that were conducted* (include results that were inconclusive or negative for rubella) Include serology (rubella IgG, IgM), and PCR results on all tissue types including blood, urine, lens tissue. If test not done, write ND. If more than one test of each type, write each on a new line. If additional serology or PCR tests were done, use the additional lines to complete these

Type of test conducted	**Date of specimen collection** (write 'ND' if test not done)	**Specimen type**	**Laboratory where test conducted**	**Result**	**Laboratory reference number**
Rubella IgG					
Rubella IgM					
PCR (1)					
PCR (2)					

B9. *Were there any other congenital defects in this child?* Yes ☐ No ☐ Unknown ☐

If yes describe: _____

B10. *Were there other infections present in this child at time of CRS diagnosis?*

HIV positive Yes ☐ No ☐ Unknown ☐ HIV exposed Yes ☐ No ☐ Unknown ☐ Congenital syphilis Yes ☐ No ☐ Unknown ☐ Congenital toxoplasmosis Yes ☐ No ☐ Unknown ☐ Congenital CMV Yes ☐ No ☐ Unknown ☐ Congenital HSV Yes ☐ No ☐ Unknown ☐ Other ☐ Describe:_____

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B11. *What supportive (or other) treatment was given from birth up until the time of diagnosis?* ICU admission Yes ☐ No ☐ Unknown ☐ ventilation Yes ☐ No ☐ Unknown ☐ cataract surgery Yes ☐ No ☐ Unknown ☐ cardiac surgery Yes ☐ No ☐ Unknown ☐ other ☐ describe:

_____

B12. *Outcome* Was there a record in the notes that this child died?: Yes ☐ No ☐ Unknown ☐ If died, what was the date of death: (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐
Was CRS the direct contributory cause of death? Yes ☐ No ☐ Unknown ☐
If alive, what was the last recorded date of contact with health services in the notes: (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐

Part C. Mother's clinical details *(obtain these from mother's antenatal file or by clinical interview with mother)*

C1. *Obstetric history.* How many times was mother pregnant (gravida) including this pregnancy: ☐☐.
How many times did mother carried a pregnancy to term (parity) including this pregnancy: ☐☐.

C2. *What was mother's age when the infant patient with CRS was born?*: years: ☐☐ Unknown ☐.

C3. *Did mother receive ante-natal care?* Yes ☐ No ☐ Unknown ☐ if yes, how many ANC visits did the mother attend: ☐☐.

C4. *Did the mother have a rubella-like illness during pregnancy*?: Yes ☐ No ☐ Unknown

C5. *If a rubella-like illness did occur what was the date of the illness?* (dd/mm/yyyy) ☐☐/☐☐/☐☐☐☐ and were any of the following present?

	Y N U	If yes, date of onset (dd/mm/yyyy)
Conjunctivitis	☐ ☐ ☐	☐☐/☐☐/☐☐☐☐
Maculopapular rash	☐ ☐ ☐	☐☐/☐☐/☐☐☐☐
Lymph nodes swollen	☐ ☐ ☐	☐☐/☐☐/☐☐☐☐
Arthralgia/arthritis	☐ ☐ ☐	☐☐/☐☐/☐☐☐☐
Other complications	☐ ☐ ☐	☐☐/☐☐/☐☐☐☐

C6. *Risk factors for maternal rubella*

	Y N U
Was the mother in contact with someone with confirmed rubella during pregnancy?	☐ ☐ ☐
Were there any cases of fever/rash in household members during the pregnancy?	☐ ☐ ☐
Had the mother received rubella vaccination prior to pregnancy?	☐ ☐ ☐
Was the mother tested for rubella as part of antenatal care?	☐ ☐ ☐

C7. What was the source of data for the answers to these questions? (mark all that apply) Maternal antenatal record? Yes ☐ No ☐ Interview of mother Yes ☐ No ☐