Annexure 3.1: CRS Case investigation form

Case ID: Region: District:

Date of notification: ___ /___ /___ Date of investigation: ___ /___ /___ Date of reporting: ___ /___ /___

A. Identification

Name of the child: _____ Sex: ☐Male ☐Female

Date of birth: ___ /___ /___ if not available – age in months_____
Address:_____

Place infant delivered: _____

Name of mother:_____

B. Clinical signs and symptoms

Gestational age (weeks) at birth:_____ Birth weight (grams): _____

Group A (please complete all)	**Group B** (please complete all)
Congenital heart disease: Yes ☐ No ☐ Unknown ☐	Purpura: Yes ☐ No ☐ Unknown ☐
If yes, specify defect:_____	Microcephaly: Yes ☐ No ☐ Unknown ☐
Cataracts: Yes ☐ No ☐ Unknown ☐	Meningoencephalitis Yes ☐ No ☐ Unknown ☐
Congenital glaucoma: Yes ☐ No ☐ Unknown ☐	Jaundice: Yes ☐ No ☐ Unknown ☐
Pigmentary retinopathy: Yes ☐ No ☐ Unknown ☐	Splenomegaly: Yes ☐ No ☐ Unknown ☐
Hearing impairment: Yes ☐ No ☐ Unknown ☐	Developmental delay: Yes ☐ No ☐ Unknown ☐
	Radiolucent bone disease: Yes ☐ No ☐ Unknown ☐

Other abnormalities: Yes ☐ No ☐ If yes please describe:_____

Name of physician who examined infant:_____

City/town/village:_____ Telephone:_____

Present status of infant: Alive ☐ Dead ☐

If dead, cause of death: _____

Autopsy conducted: Yes ☐ No ☐ Unknown ☐

Autopsy findings:_____

Autopsy date:_____/____/_____

C. Maternal history/Antenatal care

Number of previous pregnancies: Mother's age (years):

Vaccinated against rubella: Yes □ No □ Unknown □ If yes, give date: ___/___/___

Rubella like illness during pregnancy: Yes □ No □ Unknown □ If yes, Month of pregnancy:_____

Maculopapular rash: Yes □ No □ Unknown □ If yes, date of onset___/___/___

Lymph nodes swollen: Yes □ No □ Unknown □ If yes, date of onset___/___/___

Arthralgia/arthritis: Yes □ No □ Unknown □ If yes, date of onset___/___/___

Other complications Yes □ No □ Unknown □ If yes, date of onset___/___/___

Was rubella laboratory-confirmed in the mother Yes □ No □ Unknown □

If yes, when (date): ___/___/___

Was the mother exposed during pregnancy to person of any age with maculopapular (e.g. not vesicular) rash illness with fever Yes □ No □ Unknown □ If yes, when (date): ___/___/___

Month of pregnancy:_____

Describe where:_____

Did the mother travel during pregnancy: Yes □ No □ Unknown If yes, when (date): ___/___/___

Month of pregnancy:_____ Describe where:_____

D. Infant/child laboratory investigations

First specimen:

Specimen collected: Yes □ No □ Unknown □

Type of specimen: Serum □ Throat swab □ Urine □ Other □

Date of specimen collection: ___/___/___ Date specimen sent: ___/___/___

Date specimen received in Lab: _____/____/_____

Rubella IgM: Not tested □ Positive □ Negative □ In process □ Inconclusive □

Rubella IgG: Not required □ Not tested □ Positive □ Negative □ In process □ Inconclusive □

Second specimen:

Specimen collected: Yes □ No □ Unknown □ Not required □

Type of specimen: Serum □ Throat swab □ Urine □ Cerebrospinal fluid □ Other □

Date of specimen collection: ___/___/___ Date specimen sent: ___/___/___

Date specimen received in Lab: _____/____/_____

Rubella IgM: Not required □ Not tested □ Positive □ Negative □ In process □ Inconclusive □

Rubella IgG: Not required □ Not tested □ Positive □ Negative □ In process □ Inconclusive □

Sustained 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_____

Date of laboratory result (first validated result) reported: ____/____/____

E. Final classification

CRS □ Discarded □ If discarded, please specify:_____

Case classification as Laboratory-confirmed □ Clinical □

Classification by origin: Endemic □ Imported □ Import-related □ Unknown □

Date of final classification: ____/____/____

Investigator:_____