North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

RUBELLA
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 36

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Was testing for rubella or measles done? ☐ Yes ☐ No ☐ Unknown

Please specify disease ☐ Measles ☐ Rubella

Date IgM specimen taken Month Day Year

IgM result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not done ☐ Unknown

Date IgG acute specimen taken Month Day Year

IgG result ☐ Signficant rise in IgG ☐ No significant rise in IgG ☐ Indeterminate ☐ Pending ☐ Not done ☐ Unknown

Date IgG convalescent specimen taken Month Day Year

Specify other lab method

Other results ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not done ☐ Unknown

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U

If yes, symptom onset date (mm/dd/yyyy): __/__/____

CHECK ALL THAT APPLY:

Fever ☐ Y ☐ N ☐ U
- ☐ Yes, subjective ☐ No
- ☐ Yes, measured ☐ Unknown
- Highest measured temperature_____
- Fever onset date (mm/dd/yyyy):_____

Skin rash ☐ Y ☐ N ☐ U
- Onset date (mm/dd/yyyy):_____
- **Anatomic site rash began:**
  - ☐ Head
  - ☐ Trunk
  - ☐ Upper extremities
  - ☐ Lower extremities
- Observed by health care provider ☐ Y ☐ N ☐ U
- Duration of rash:_____
  - Unit: ☐ Hours ☐ Days ☐ Weeks
- **Location:**
  - ☐ All over the body (generalized)
  - ☐ Generalized, predomiately central/torso/back (centripetal)
  - ☐ Generalized, predominately face/hands/feet (centrifugal)
  - ☐ Localized/Focal
  - ☐ Palms and soles
  - ☐ Unknown
- **Appearance of rash** (choose all that apply):
  - ☐ Macular Papular ☐ Pustular ☐ Unknown
  - ☐ Petechial ☐ Bullous ☐ Vesicular

Skin itching (pruritis) ☐ Y ☐ N ☐ U

Conjunctivitis ☐ Y ☐ N ☐ U

Runny nose and/or teary eyes (coryza) ☐ Y ☐ N ☐ U

Thrombocytopenia ☐ Y ☐ N ☐ U

Encephalitis ☐ Y ☐ N ☐ U

Joint pains (arthralgias) ☐ Y ☐ N ☐ U

Arthralgia/arthritis ☐ Y ☐ N ☐ U

Lymphadenopathy ☐ Y ☐ N ☐ U

Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐ Y ☐ N ☐ U
- **If yes, specify:** _____

PREGNANCY

Is the patient currently pregnant? ☐ Y ☐ N ☐ U
- Estimated delivery date (mm/dd/yyyy):_____
- Give number of weeks gestation at onset of illness:_____

Has the mother received prenatal care? ☐ Y ☐ N ☐ U
- Prenatal provider name_____
- OB Name _____
- Street address_____
- City _____
- State _____
- Zip code _____
- Phone (_____) _____

Does the patient have prior evidence of serological immunity to rubella? ☐ Y ☐ N ☐ U
- Test date (mm/dd/yyyy):_____
- Result:
  - ☐ Positive
  - ☐ Negative
  - ☐ Equivocal
  - ☐ Unknown

Was previous rubella disease confirmed serologically? ☐ Y ☐ N ☐ U
- Date of disease (mm/dd/yyyy):_____

MATERNAL INFORMATION

Please complete if the child is 12 months of age or younger:

Was the biologic mother born outside the US? ☐ Y ☐ N ☐ U
- If yes, country:_____
- Date of biologic mother's arrival in the US (mm/dd/yyyy):_____

Did the biologic mother ever have evidence of serological IgG immunity? ☐ Y ☐ N ☐ U
- Test date (mm/dd/yyyy):_____
- Result:
  - ☐ Positive
  - ☐ Negative
  - ☐ Equivocal
  - ☐ Unknown

(CONTINUED NEXT PAGE)

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE (CONTINUED)

Was the child's biologic mother immunized with vaccine against this specific disease? ☐Y ☐N ☐U

If yes, type of vaccine:

Vaccine #1:

Date of vaccination (mm/dd/yyyy):____/____/____

Vaccine type:_____

Manufacturer: _____

Product/trade name: _____

Lot number:_____

Vaccine #2:

Date of vaccination (mm/dd/yyyy):____/____/____

Vaccine type:_____

Manufacturer: _____

Product/trade name: _____

Lot number:_____

Reason for inadequate vaccination:

☐ Religious exemption
☐ Medical exemption
☐ Medical contraindication
☐ Philosophical exemption (outside NC only)
☐ Laboratory evidence of previous disease
☐ Physician diagnosis of previous disease
☐ Under age for vaccination
☐ Parental refusal
☐ Missed opportunities
☐ Unknown
☐ Other, specify:_____

Source of vaccine information:

☐ Patient's or Parent's verbal report
☐ Physician
☐ Medical record *(Note: Any vaccine on a medical record should be recorded in the NCIR)*
☐ Certificate of immunization record *(Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)*
☐ Patient vaccine record
☐ School record
☐ Other, specify:_____
☐ NCIR record
☐ Unknown

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U

Hospital name: _____

City, State:_____

Hospital contact name: _____

Telephone: (_____) _____ - _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy):____/____/____

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U

If yes, specify name and relationship to person:

Is the patient part of an outbreak of this disease? ☐Y ☐N

VACCINE

Has patient/contact ever received rubella-containing vaccine? ☐Y ☐N ☐U

If yes, date of vaccination #1

(mm/dd/yyyy) _____

Vaccine type:_____

Manufacturer: _____

Product/trade name: _____

Lot number:_____

If yes, date of vaccination #2(mm/dd/yyyy) _____

Vaccine type:_____

Manufacturer: _____

Product/trade name: _____

Lot number:_____

Vaccine date unknown ☐Y ☐N

If no, reason for inadequate vaccination:

☐ Religious exemption
☐ Medical exemption
☐ Medical contraindication
☐ Philosophical exemption (outside NC only)
☐ Laboratory evidence of previous disease
☐ Physician diagnosis of previous disease
☐ Under age for vaccination
☐ Parental refusal
☐ Missed opportunities
☐ Unknown
☐ Other, specify:_____

Source of vaccine information:

☐ Patient's or Parent's verbal report
☐ Physician
☐ Medical record
☐ Certificate of immunization record
☐ Patient vaccine record
☐ School record
☐ Other, specify:_____
☐ NCIR record
☐ Unknown

If yes, number of doses received on or after first birthday: _____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U

Specify _____

Autoimmune disease ☐Y ☐N ☐U

Specify _____

Other underlying illness ☐Y ☐N ☐U

Please specify: _____

Was the patient receiving any of the following treatments or taking any medications?

Antibiotics ☐Y ☐N ☐U
For what medical condition?

Chemotherapy ☐Y ☐N ☐U
If yes, was therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?

Radiotherapy ☐Y ☐N ☐U
If yes, was therapy within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?

Systemic steroids/corticosteroids, including steroids taken by mouth or injection ☐Y ☐N ☐U
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?

Immunosuppresive therapy, including anti-rejection therapy ☐Y ☐N ☐U
If yes, specify: _____
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?

Aspirin or aspirin-containing product ☐Y ☐N ☐U
If yes, was medication taken within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?

REASON FOR TESTING

Why was the patient tested for this condition?

☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household / close contact to a person reported with this disease
☐ Other, specify_____
☐ Unknown

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____

Survived? ☐Y ☐N ☐U
Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐U
Patient died in North Carolina? ☐Y ☐N ☐U
County of death:_____
Died outside NC? ☐Y ☐N ☐U
Specify where:_____
Autopsy performed? ☐Y ☐N ☐U
Facility where autopsy was performed:

Patient autopsied in NC? ☐Y ☐N ☐U
County of autopsy:_____
☐ Autopsied outside NC, specify where:_____
Source of death information (select all that apply):
Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.
☐ Death certificate
☐ Autopsy report final conclusions
☐ Hospital/physician discharge summary
☐ Other:_____

Cause of death:_____

Death date (mm/dd/yyyy):_____

TREATMENT

Did patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U

If yes, specify antibiotic name:_____

Dose_____

Date antibiotic began (mm/dd/yyyy):_____

Date antibiotic ended (mm/dd/yyyy):_____

Did the patient receive medical care for this illness? ☐Y ☐N ☐U

Specify level(s) of care (check all that apply):

☐ Outpatient
☐ Emergency department
☐ Inpatient
☐ Other
☐ Unknown

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident North Carolina
- ☐ Resident of another state or US territory
- ☐ Foreign visitor
- ☐ Refugee
  - Refugee camp(s)? ☐ Y ☐ N ☐ U
  - Name of camp _____
  - Location of camp _____
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US _____
- ☐ Recent immigrant
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US _____
- ☐ Foreign adoptee
  - Country of birth _____
  - Last country prior to arrival in US _____
  - Date of entry to US _____
- ☐ None of the above

Did patient have a travel history during the 7 days prior to onset of symptoms until 4 days after rash onset? ☐ Y ☐ N ☐ U
- Travel dates: From: _____ until _____
- To city: _____ State: _____
- To country: _____
- Reason(s) for travel:
  - ☐ Vacation / tourism
  - ☐ Organized tour
  - ☐ Business related, specify _____
  - ☐ Military related
  - ☐ Visit to family / friends
  - ☐ Peace corps
  - ☐ Airline / Ship crew
  - ☐ Missionary or dependent
  - ☐ Refugee / Immigrant
  - ☐ Student / Teacher
  - ☐ Unknown
  - ☐ Other _____
- Mode(s) of transportation (check all that apply)
  - ☐ Airplane
  - ☐ Ship / boat / ferry
    - Cruise ship? ☐ Y ☐ N ☐ U
    - Specify cruise line _____
  - ☐ Train / subway
  - ☐ On foot
  - ☐ Bus/taxi/shuttle
  - ☐ Automobile / motorcycle
  - ☐ Other, specify: _____

Was patient pregnant while traveling? ☐ Y ☐ N ☐ U
- If yes, was travel during the first trimester of pregnancy? ☐ Y ☐ N ☐ U

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U
- Name: _____

Did patient have contact with a person with travel history during the period of interest? ☐ Y ☐ N ☐ U
- Contact's name: _____
- Travel dates: From: _____ until _____
- To city: _____
- To state: _____
- To country: _____
- Is contact a:
  - ☐ Resident of another state or US territory
  - ☐ Foreign visitor
  - ☐ Recent immigrant
  - ☐ Refugee
  - ☐ Foreign adoptee
  - ☐ Unknown
  - ☐ Other, specify: _____

Notes:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U
- Name of care provider: _____
- Address: _____
- City: _____ State: _____
- Zip code: _____ County: _____
- Contact name: _____
- Telephone: (_____) _____

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U
- Name of child care provider: _____
- Address: _____
- City: _____ State: _____
- Zip code: _____ County: _____
- Contact name: _____
- Telephone: (_____) _____

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U
- Name of child care provider: _____
- Address: _____
- City: _____ State: _____
- Zip code: _____ County: _____
- Contact name: _____
- Telephone: (_____) _____

Is patient a student? ☐ Y ☐ N ☐ U
- Type of school:
  - ☐ NC Public School (preK-12)
  - ☐ NC Private School (preK-12)
  - ☐ Other School (preK-12)
  - ☐ Community College/College/University
  - ☐ Other academic institution (i.e. trade school, professional school, etc)
- Name: _____
- Address: _____
- City: _____ State: _____
- Zip code: _____ County: _____
- Contact name: _____
- Telephone: (_____) _____
- Specify grade: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U
- Type of school
  - ☐ NC Public School (preK-12)
  - ☐ NC Private School (preK-12)
  - ☐ Other School (preK-12)
  - ☐ Community College/College/University
  - ☐ Other academic institution (i.e. trade school, professional school, etc)
- Name: _____
- Address: _____
- City: _____ State: _____
- Zip code: _____ County: _____
- Telephone: (_____) _____

Notes:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 days prior to onset of symptoms until 4 days after rash onset did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? ☐ Y ☐ N ☐ U
- Name of facility: _____
- Dates of contact: _____

During the 7 days prior to onset of symptoms until 4 days after rash onset, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U
- If yes, specify: _____

In what setting was the patient most likely exposed?
- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) _____
- ☐ Unknown

Does the patient have any other risk factors for this disease? ☐ Y ☐ N ☐ U
- Specify: _____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐ Y ☐ N
- Check all that apply:
  - ☐ Work
  - ☐ Child care
  - ☐ School
  - ☐ Sexual behavior
  - ☐ Blood and body fluid
  - ☐ Other, specify _____
- Date control measures issued: _____
- Date control measures ended: _____
- Was patient compliant with control measures? ☐ Y ☐ N

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐ Y ☐ N
- If yes, specify: _____

Were written isolation orders issued? ☐ Y ☐ N
- If yes, where was the patient isolated? _____
- Date isolation started? _____
- Date isolation ended? _____
- Was the patient compliant with isolation? ☐ Y ☐ N

Were written quarantine orders issued? ☐ Y ☐ N
- If yes, where was the patient quarantined? _____
- Date quarantine started? _____
- Date quarantine ended? _____
- Was the patient compliant with quarantine? ☐ Y ☐ N

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 7 days prior to onset of symptoms until 4 days after rash onset, did the patient have any of the following health care exposures?

Emergency Dept. (not hospitalized)... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown
  ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Hospital ..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):_____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

LTC facility—resident..... ☐ Y ☐ N ☐ U
- Visit/admit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Has patient been discharged? ..... ☐ Y ☐ N ☐ U
- Discharge date (mm/dd/yyyy):_____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Outpatient facility—patient..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):_____
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Visitor to health care setting ..... ☐ Y ☐ N ☐ U
- Visit date (mm/dd/yyyy):_____
- Until date (mm/dd/yyyy):_____
- Frequency:
  ☐ Once
  ☐ Multiple times within this time period
  ☐ Daily
- Facility name_____
- City_____State _____
- Country _____
- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ Not applicable
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Worked or volunteered in health care or clinical setting ..... ☐ Y ☐ N ☐ U
- Facility name_____
- City_____State _____
- Country _____
- Occupation:
  ☐ Physician
  ☐ Physician's assistant or nurse practitioner
  ☐ Nurse
  ☐ Laboratory
  ☐ Other
  ☐ Unknown
- Specify work setting or volunteer duties:

- Was facility notified regarding ill patient?
  ☐ Yes ☐ No ☐ Unknown ☐ N/A
- Name of person notified _____
- Date notified (mm/dd/yyyy): _____

Other, specify_____

_____

Has the patient ever worked in a healthcare or clinical laboratory setting? ..... ☐ Y ☐ N ☐ U
- If yes, specify and give details: _____

_____

During the timeframe displayed above, has the patient had other blood and body fluid exposures?..... ☐ No ☐ Other ☐ Unknown

Human saliva/oral secretions exposure (e.g. shared water bottle, cigarettes, eating utensils, kissing)**?**..... ☐ Y ☐ N ☐ U

If yes, specify and give details:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U
- Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others?..... ☐ Y ☐ N ☐ U
- Who was interviewed?

Were health care providers consulted?..... ☐ Y ☐ N ☐ U
- Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
- City _____
- County_____

☐ Outside NC, but within US
- City _____
- State _____
- County_____

☐ Outside US
- City _____
- Country _____

☐ Unknown

Notes:

Rubella (German measles)

2013 Case Definition

CSTE Position Statement(s): 12-ID-09

Case Classification

Suspected
Any generalized rash illness of acute onset that does not meet the criteria for probable or confirmed rubella or any other illness.

Probable
In the absence of a more likely diagnosis, an illness characterized by all of the following:

- Acute onset of generalized maculopapular rash; **and**
- Temperature greater than 99.0° F or 37.2° C, if measured; **and**
- Arthralgia, arthritis, lymphadenopathy, or conjunctivitis; **and**
- Lack of epidemiologic linkage to a laboratory-confirmed case of rubella; **and**
- Noncontributory or no serologic or virologic testing.

Confirmed
A case with or without symptoms who has laboratory evidence of rubella infection confirmed by one or more of the following laboratory tests:

- Isolation of rubella virus; **or**
- Detection of rubella-virus specific nucleic acid by polymerase chain reaction; **or**
- IgG seroconversion† or a significant rise between acute- and convalescent-phase titers in serum rubella IgG antibody level by any standard serologic assay; **or**
- Positive serologic test for rubella IgM antibody†*

OR
An illness characterized by all of the following:

- Acute onset of generalized maculopapular rash; **and**
- Temperature greater than 99.0°F or 37.2°C; **and**
- Arthralgia, arthritis, lymphadenopathy, or conjunctivitis; **and**
- Epidemiologic linkage to a laboratory-confirmed case of rubella.

†Not explained by MMR vaccination during the previous 6-45 days.

*Not otherwise ruled out by more specific testing in a public health laboratory.

Epidemiologic Classification

Internationally imported case: An internationally imported case is defined as a case in which rubella results from exposure to rubella virus outside the United States as evidenced by at least some of the exposure period (12–23 days before rash onset) occurring outside the United States and the onset of rash within 23 days of entering the United States and no known exposure to rubella in the United States during that time. All other cases are considered U.S.-acquired cases.

U.S.-acquired case: A U.S.-acquired case is defined as a case in which the patient had not been outside the United States during the 23 days before rash onset or was known to have been exposed to rubella within the United States. These cases are subclassified into four mutually exclusive groups:

- **Import-linked case:** Any case in a chain of transmission that is epidemiologically linked to an internationally imported case.
- **Imported-virus case:** A case for which an epidemiologic link to an internationally imported case was not identified but for which viral genetic evidence indicates an imported rubella genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any rubella virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.
- **Endemic case:** A case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of rubella virus transmission continuous for ≥12 months within the United States.

Epidemiologic Classification, continued

- **Unknown source case:** A case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases. States may also choose to classify cases as “out-of-state-imported” when imported from another state in the United States. For national reporting, however, cases will be classified as either internationally imported or U.S.-acquired.

Comment(s)

Serum rubella IgM test results that are false positives have been reported in persons with other viral infections (e.g., acute infection with Epstein-Barr virus [infectious mononucleosis], recent cytomegalovirus infection, and parvovirus infection) or in the presence of rheumatoid factor. Patients who have laboratory evidence of recent measles infection are excluded.