

Rubella Aircraft Contact Investigation Outcome Reporting Form

Return completed form by secure email to airadmin@cdc.gov (preferred) or fax to 404-471-8121 with the following text in the SUBJECT line: Outcome Reporting Form DGMH ID #####

1. FLIGHT INFORMATION				
DGMH ID#	Arrival date	Departure city/airport	Arrival city/airport	Index case seat
2. INDEX CASE CLINICAL AND LAB INFORMATION				
3. CONTACT INFORMATION				
Last name, First name	Assigned seat	Gender	DOB (mm/dd/yyyy)/Age (yrs)	
4. CONTACT/INTERVIEW INFORMATION				
Were you able to contact this person? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? <input type="checkbox"/> Incorrect locating information <input type="checkbox"/> No longer at temporary address but still in the U.S. <input type="checkbox"/> No response <input type="checkbox"/> Returned to country of residence <input type="checkbox"/> HD didn't attempt follow-up <input type="checkbox"/> Other, specify _____ (Skip to Section 9) If yes, date contacted: ____/____/____				
Was contact interviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No, why not? <input type="checkbox"/> Declined <input type="checkbox"/> Lives in different jurisdiction, specify _____ <input type="checkbox"/> Other, specify _____ (Skip to Section 9) <input type="checkbox"/> Yes; Actual/verified seat # _____				
Was this person a known close contact of the index case outside of this flight (e.g. family member)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", date of last known exposure to index case: _____				
When was person interviewed? <input type="checkbox"/> During incubation period <input type="checkbox"/> After incubation period <input type="checkbox"/> At both times				
5. IMMUNITY				
MMR (or other rubella-containing vaccine) or history of disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not vaccinated <input type="checkbox"/> One dose of vaccine <input type="checkbox"/> Two doses of vaccine <input type="checkbox"/> Three doses of vaccine <input type="checkbox"/> Immunized, number of doses unknown <input type="checkbox"/> History of disease <input type="checkbox"/> Immunity established by serology <input type="checkbox"/> Unknown				
6. RUBELLA INTERVENTION RELATED TO EXPOSURE ON THE FLIGHT				
Did contact receive intervention for this exposure to rubella (not routinely recommended)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate what s/he/they received and the date: <input type="checkbox"/> Immunoglobulin; Date received: ____/____/____ <input type="checkbox"/> Other, specify: _____ Reason for intervention: _____				
7. HEALTH SINCE FLIGHT				
Is this person pregnant? <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Yes; what trimester at time of the flight? <input type="checkbox"/> 1 st <input type="checkbox"/> 2 nd <input type="checkbox"/> 3 rd				
Did contact report any signs or symptoms of rubella? <input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to Section 9) If yes, check all that apply: <input type="checkbox"/> Fever (Max temp measured _____°C/F) <input type="checkbox"/> Rash <input type="checkbox"/> Cough <input type="checkbox"/> Coryza <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Arthritis/arthralgia				
Check any of the following potential rubella exposures this person may have had in the 23 days prior to symptom onset: <input type="checkbox"/> Visited/lives in a country with endemic rubella <input type="checkbox"/> Exposed to a person with a confirmed rubella case <u>other than the index case on the flight</u> <input type="checkbox"/> Other, specify _____				
8. DIAGNOSIS				
Was this person diagnosed with rubella? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If unknown, why? <input type="checkbox"/> Declined medical evaluation <input type="checkbox"/> Not interviewed after incubation period (max of 23 days after flight) <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Other, specify _____ If yes, how was diagnosis made? (Check all that apply) <input type="checkbox"/> IgM <input type="checkbox"/> Paired IgG <input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Epi-linked <input type="checkbox"/> Clinical diagnosis <input type="checkbox"/> Other, specify _____				
9. FORM COMPLETION				
Person completing form: _____			Date form completed: ____/____/____	
10. COMMENTS				