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CRS CASE DEFINITIONS

1. Suspected CRS:

A child <1 year with

- maternal history of rubella in pregnancy

AND/OR

- heart disease, or deafness, or eye signs:

white pupil (cataract); diminished vision; pendular eye movement (nystagmus); squint; smaller eye ball (micropthalmos); larger eye ball (congenital glaucoma)

2. Clinically confirmed CRS:

A child <1 year with two complications in *group (a)* OR one from *(a)* and one from *(b)*

Group (a)

cataract(s), congenital glaucoma, congenital heart disease, loss of hearing, pigmentary retinopathy

Group (b)

purpura, splenomegaly, microcephaly, mental retardation, meningoencephalitis, radiolucent bone disease, jaundice with onset within 24 hours after birth.

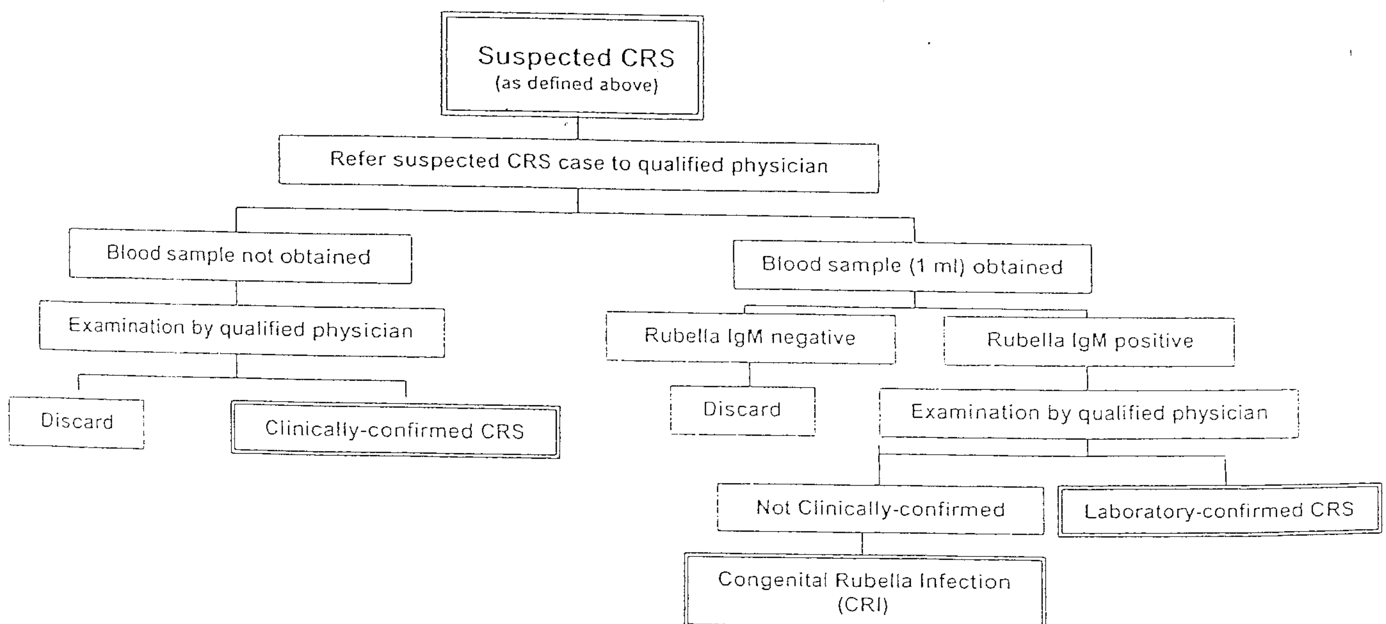
3. Laboratory-confirmed CRS:

An infant with a positive blood test for rubella-specific IgM and clinically-confirmed CRS.

4. Congenital rubella infection (CRI):

An infant with a positive blood test for rubella-specific IgM who does not have clinically-confirmed CRS.

CRS Investigation Algorithm (New Case)



* *Source: WHO*

Sultanate of Oman

Ministry of Health

Directorate General of Health Affairs

Department of Surveillance & Disease Control

CRS Initial Assessment Form

Region : ....

Reporting Institution: ....

Unique Identifier: ☐☐ ☐☐ ☐☐ ☐☐☐ *(will be provided by DSDC)*

Mother's 1st Name:	2nd Name:	3rd Name:	Tribe:
Husband's 1st Name:	2nd Name:	3rd Name:	Tribe:
Mother's Age: Father's Age:	Parent Institution:	House No: Tel.No:	Occupation: ☐ Housewife ☐ Other specify
Nationality:	Willayat:	Sheikh's Name:	
Date of Delivery: dd ☐☐ mm ☐☐ yyyy ☐☐☐☐		ANC No:	IPD No:
Rubella Immunization: ☐Y N Not Known Date ☐☐ ☐☐		Other Disorders during Pregnency ☐ Yes ☐ No If Yes Specify:	
Gravida:	Para: / Date of last delivery: dd ☐☐ mm ☐☐ yyyy ☐☐☐☐	Outcome of last delivery : ☐ FTND ☐ Preterm ☐ LBW ☐ FD	Gestational Age on Admission: In Weeks: ☐☐
Rash during Pregnancy: dd ☐☐ mm ☐☐ yyyy ☐☐☐☐		Known Rubella contact during current pregnancy:	

Laboratory Investigations

Rubella IgG: ☐ Pos / ☐ Neg Test Used: Titre: Date of Specimen: Manufacturer:

Rubella IgM: ☐ Pos / ☐ Neg Test Used: Titre: Date of Specimen: Manufacturer:

NEONATE

Birth Weight (gm)	Gestation (weeks)	Head Circumference (cm):
Multiple Pregnancy: If Yes number born:	Birth Order:	

Neonatal Findings

- ☐ Hepatomegaly
- ☐ Splenomegaly
- ☐ Hepatitis
- ☐ Prolonged Jaundice
- ☐ Purpura
- ☐ Thrombocytopaenia
- ☐ Failure to thrive
- ☐ Any Other:

Laboratory Investigations

Rubella IgG: ☐ Pos / ☐ Neg	Rubella IgM: ☐ Pos / ☐ Neg
Test Used:	Test Used:
Titre:	Titre:
Date of Specimen:	Date of Specimen:
Manufacturer:	Manufacturer:

REMARKS

Name of Physician:	Date of Notification:	Signature & Stamp:

MR-XXX

Sultanate of Oman

Ministry of Health

CRS Assessment Form

Directorate General of Health Affairs
Department of Surveillance & Disease Control

Region : ....
Reporting Institution: ....

Unique Identifier: HI Code ☐☐☐ S No ☐☐☐

EYE DEFECTS (Reporting by Ophthalmologist)

Eye defects: ☐ Yes ☐ No

	RIGHT EYE			LEFT EYE		
	Yes	No	Not known	Yes	No	Not known
Cataract	☐	☐	☐	☐	☐	☐
Microphthalmos	☐	☐	☐	☐	☐	☐
Rubella Retinitis	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Disciform Maculopathy	☐	☐	☐	☐	☐	☐
Ketatoconus	☐	☐	☐	☐	☐	☐
Corneal Hydrops	☐	☐	☐	☐	☐	☐
Absorbed Lens	☐	☐	☐	☐	☐	☐
Other Specify: ____________	☐	☐	☐	☐	☐	☐

Has surgery been performed? ☐ Yes ☐ No ☐ Not known

If yes, specify:_________________________ Date: Day........ / mm........ / yy..........

Has rubella affected the child's vision? ☐ Yes ☐ No ☐ Not possible

If yes, degree of visual impairment:

	None	<6/6 But ≥ 6/18	<6/18 but ≥ 6/60	<3/60	<6/60 but ≥3/60	No PL
RIGHT	☐	☐	☐	☐	☐	☐
LEFT	☐	☐	☐	☐	☐	☐

NEUROLOGICAL / BEHAVIOURAL ABNORMALITIES (Reporting by Pediatrician/Neurologist)

	Yes	Suspected	No	Not known
Neurological / Behavioural abnormalities	☐	☐	☐	☐
Microcephaly	☐	☐	☐	☐
Cerebral palsy	☐	☐	☐	☐
If yes, specify;				
Mental impairment:	☐	☐	☐	☐
If yes, specify;				
Behavioural problems:	☐	☐	☐	☐
If yes, specify;				
Other:	☐	☐	☐	☐
If yes, specify;				

Sultanate of Oman

Ministry of Health

Directorate General of Health Affairs
Department of Surveillance & Disease Control

CRS Follow-up Form : 2

Region : ....

Reporting Institution: ....

Unique Identifier: ☐☐ ☐☐ ☐☐ ☐☐☐ *(will be provided by DSDC)*

A. MOST RECENT CLINICAL EXAMINATION

(Pediatrician/Cardiologist)

Name of Reporting Doctor: ....

Date when last seen: dd........./ mm......... / yyyy...........

Congenital Heart Defects: Yes ☐ Suspected ☐ No ☐ Not known ☐

If yes, specify:

Has surgery been performed? Yes ☐ No ☐ Not known ☐

If yes, specify: Date of Surgery: / /

B. HEARING

(ENT Specialist)

Name of Reporting Doctor: ....

Date of last formal assessment: dd /mm / yyyy Not done ☐

Method of assessment (specify):

Is there a hearing impairment? Yes ☐ Suspected ☐ No ☐ Not known ☐

If yes, date when first confirmed: dd / mm / yyyy

Type of hearing loss:	Yes	No	Not known
Sensorineural	☐	☐	☐
Conductive	☐	☐	☐
Mixed	☐	☐	☐

Degree of hearing loss:	None	Mild	Moderate	Severe	Profound	Not known
RIGHT	☐	☐	☐	☐	☐	☐
LEFT	☐	☐	☐	☐	☐	☐

Have aids been fitted? Yes ☐ No ☐ Not known ☐ If yes, date fitted

(Note: Please provide most recent audiogram)

C. SPEECH DELAY / IMPAIRMENT

(ENT Specialist at Secondary/Tertiary level)

Name of Reporting Doctor (ENT): ....

Speech delay / impairment: Yes ☐ Suspected ☐ No ☐ Not known ☐

If yes, specify:

Sultanate of Oman

Ministry of Health

Directorate General of Health Affairs
Department of Surveillance & Disease Control

CRS Follow-up Form : 3

Region : ....

Reporting Institution: ....

Unique Identifier: ☐☐ ☐☐ ☐☐ ☐☐☐ *(to be provided by DSDC)*

A. ENDOCRINE DISORDERS (DIABETES ETC.)

Name of Reporting Doctor: .... *(Pediatrician/Endocrinologist)*

Endocrine Disorders, Diabetes etc. ☐ Yes ☐ No ☐ Not known

If yes, specify:

B. ANY OTHER DISORDERS NOT ALREADY MENTIONED?

Name of Reporting Doctor: .... *(Pediatrician)*

Any other disorders not already mentioned? ☐ Yes ☐ No ☐ Not known

If yes, specify:

Is the child still living? ☐ Yes ☐ No

If no, give cause and date of death:

Has the child received MMR or Rubella vaccine? ☐ Yes ☐ No ☐ Not known

If yes, vaccine type and date:

If now appropriate please give information on school placement & special educational and/or rehabilitation requirements:

Name of pediatrician submitting the Final Assessment & the completed report:

Date: Stamp & Signature