

National Centre for Disease Control
22- Sham Nath Marg, Delhi -54
Rubella Case Investigation Form

Name	
Age / Sex	
Address and telephone no.	
Name of the Doctor	
Clinical Data (Sign & Symptoms)	
Fever <input type="checkbox"/> yes <input type="checkbox"/> No	If Yes , Temperature (°)
Rash <input type="checkbox"/> yes <input type="checkbox"/> No	If Yes, duration of rash (in Days)
Date of Fever onset	
Date of Rash onset	
Type of Rash	<input type="checkbox"/> Maculopapular <input type="checkbox"/> Other <input type="checkbox"/> Vesicular <input type="checkbox"/> Unknown
Any other Symptoms	
Vaccination History	
Vaccinated for Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Vaccine	
No. of Doses	
Date of Last Dose	
Source of Vaccination	