VZV Specimen Collection Form

UNIQUE IDENTIFIER (ASSIGNED BY CDC) ____________

PATIENT INFORMATION

Name (Last, First): ____________
Date of Birth: ____ /____ /____ or Age (yrs): ________
Sex: ☐ Male ☐ Female
Address: ____________
City/State/Zip: ____________
Phone: ____________ ____________

PROVIDER INFORMATION

Name: ____________
Institution: ____________
Address: ____________
City/State/Zip: ____________
Phone: ____________ Fax: ____________
E-mail: ____________

SPECIMEN INFORMATION

Date Collected: _____ /_____ /_____

Source of Specimen (check all that apply):

- ☐ Skin Lesion:
- ☐ Blood
- ☐ Vesicle (fluid-filled blister)
- ☐ Cerebrospinal fluid
- ☐ Papule (bump)
- ☐ Saliva
- ☐ Macule (flat lesion)
- ☐ Other (specify):
- ☐ Crust/Scab
- ☐ Other (specify): ____________

Reason for Specimen Submission (check all that apply):

- ☐ Suspected transmission of vaccine virus
- ☐ Suspected vaccine adverse event
- ☐ Suspected vaccine failure
- ☐ Lab confirmation
- ☐ Determine patient's susceptibility
- ☐ Strain identification (wild type vs. vaccine strain)
- ☐ Other (specify): ____________

If an adverse event is suspected, has a VAERS report been submitted? ☐ Yes – VAERS number: ____________ ☐ No

CLINICAL HISTORY

Date of Rash Onset: _____ /_____ /_____

Rash Type:

- ☐ Macules (flat) Approximate Number: ________
- ☐ Papules (raised) Approximate Number: ________
- ☐ Vesicles (fluid) Approximate Number: ________

Diagnosis:

- ☐ Varicella (Chickenpox)
- ☐ Zoster (Shingles) – Dermatome: ____________
- ☐ Other (specify): ____________

Previous Chickenpox/Shingles:

Has the patient ever had chickenpox/shingles before this illness?

☐ Yes chickenpox – Age: _____ ☐ No chickenpox ☐ Unknown
☐ Yes shingles – Age: _____ ☐ No shingles ☐ Unknown

Medications:

Does the patient have any underlying medical conditions?
☐ Yes ☐ No ☐ Unknown
If yes, specify: ____________

Did the patient take steroid(s) (i.e., oral ≥2mg/kg of body weight or total of ≥20mg/day of prednisone or equivalent for persons >10kg and administered for ≥2 weeks) or immunosuppressant(s) during the month prior to rash onset?
☐ Yes ☐ No ☐ Unknown

In the week before the specimen was collected, did the patient take oral acyclovir, famciclovir, or valacyclovir?
☐ Yes ☐ No ☐ Unknown
If yes, specify: ____________

Additional Clinical Information: ____________

VZV VACCINE INFORMATION

Has the patient received varicella-containing vaccine?
☐ Yes ☐ No ☐ Unknown
If yes, which vaccine: ☐ Varivax ☐ MMRV ☐ Zostavax
Dose 1: Date: _____/_____/_____ Lot Number: ________
Dose 2: Date: _____/_____/_____ Lot Number: ________
Time since vaccination (years) if date unknown: ________

Please specify any other lab work performed:

____

CS_116988

MAIL FORM AND SPECIMEN TO: CDC • National VZV Laboratory • 1600 Clifton Road, NE • MS G-18 Atlanta, GA 30333
Tel: 404-639-3667 • Fax: 404-639-4056 • E-mail: vzvlab@cdc.gov

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http://www.cdc.gov/vaccines/vpd-vac/varicella/downloads/lab_form.pdf