Varicella Death Investigation Worksheet

NAME (Last, First)				Hospital Record No.
Address (Street and No.)	City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic	Address			Phone

---------- DETACH HERE and transmit only lower portion if sent to CDC ----------

Varicella Death Investigation Worksheet

DEMOGRAPHIC DATA

CDC NETSS id | **State** | **Case Number**

Date of Birth — Month / Day / Year

Age — Unk = 999

Age Type — 0 = 0-120 years; 1 = 0-11 months; 2 = 0-52 weeks; 3 = 0-28 days; 9 = Age unknown

Sex — M = Male; F = Female; U = Unknown

Race — N = Native Amer./Alaskan Native; A = Asian/Pacific Islander; B = African American; W = White; O = Other; U = Unknown

Ethnicity — H = Hispanic; N = Not Hispanic; U = Unknown

Date of Death — Month / Day / Year

Country of Birth

If Not Born in U.S., Case Has Lived in U.S. For ___ **Years**

Occupation — H = Health Care Worker; T = Teacher; D = Day Care Worker; M = Military Personnel; S = Staff in Institutional Setting (e.g. Correctional facilities); C = College Student; O = Other; Specify: ___

PAST MEDICAL HISTORY

History of Previous Varicella? — Y = Yes; N = No; U = Unknown

If Yes, Age When Ill — **Age** (Unk = 999); **Age Type** — 0 = 0-120 years; 1 = 0-11 months; 2 = 0-52 weeks; 3 = 0-28 days; 9 = Age unknown

Varicella Vaccine History — V = Vaccinated; N = Not Vaccinated; U = Unknown

If Ever Vaccinated — Date 1 (Month / Day / Year); Date 2 (Month / Day / Year)

If Not Vaccinated, Was there a Contraindication to Vaccination? — Y = Yes; N = No; U = Unknown
Specify: ___

Pre-Existing Condition? — Y = Yes; N = No; U = Unknown

(Check All That Apply)

- Cancer — Type: ___
- Transplant Recipient — Organ: ___
- Immune Deficiency — Type: ___
- HIV+/AIDS
- Pregnancy
- Chronic Renal Failure
- Diabetes Mellitus
- Tuberculosis
- Asthma
- Chronic Lung Disease — Specify: ___
- Chronic Dermatolgic Disorder — Specify: ___
- Other Autoimmune Disease (e.g. Lupus, Rheumatoid Arthritis) — Specify: ___
- Other — Specify: ___

For Children < 1 Year Old, Did Their Mother Have a History of Previous Varicella? — Y = Yes; N = No; U = Unknown

Did The Decedent Take Any Drugs Listed in This Section During The Month Prior to Rash Onset? — Y = Yes; N = No; U = Unknown

(Check All That Apply)

- Steroids, Systemic — Name of Steroid: ___ Dose ___ mg/day
- Steroids, Inhaled
- Aspirin
- Chemotherapy
- Immunosuppressants

ILLNESS PRIOR TO DEATH

Rash Onset — Month / Day / Year

Hospitalized? — Y = Yes; N = No; U = Unknown

Date Admitted — Month / Day / Year

If Obtainable, Please Attach a Copy of the Hospital Discharge Summary

Complications (Check All That Apply)

- **Secondary Infection** — **From:** Strep (G = Group A Beta-hemolytic; O = Other Type; U = Unknown Type) | Staph | Mixed | Other Specify: ___
- **Type of Infection:** Cellulitis | Impetigo/Infected Skin Lesions | Lymphadenitis | Abscess | Septic Arthritis | Osteomyelitis | Necrotizing Fasciitis | Toxic Shock Syndrome | Sepsis/Septicemia | Other Specify: ___
- **Pneumonia/Pneumonitis** — Etiology, if Known: ___
- **Neurologic Complications:** Cerebellitis/Ataxia | Encephalitis | Other Specify: ___
- **Reye Syndrome**
- **Congenital Varicella Syndrome**
- **Other Specify:** ___

Treatment -- Medications (Check All That Apply)

Medication	Dose mg/day	Date Started (Month / Day / Year)	Duration Days
Acyclovir — And/Or: Oral			
Acyclovir — And/Or: IV			
Famciclovir			
Valacyclovir			

- **Varicella Zoster Immune Globulin (VZIG)** — Dose ___ U's; Date Administered: Month / Day / Year
- **Aspirin**
- **Non-Steroidal Anti-inflammatory Drugs (e.g. ibuprofin)**

Note: This form has 2 sides

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LABORATORY DATA

Varicella Lab Testing? ☐ Y = Yes, N = No, U = Unknown

Serology ☐ M = IgM, G = IgG, N = Not Done, U = Unknown

Serology Results ☐ P = Positive, N = Negative, I = Indterminate, E = Pending, X = Not Done, U = Unknown

IgG Results:

	Date Specimen Collected Month	Day	Year	Titer
1st ("Acute")				
2nd ("Convalescent")				

Case Number (From Previous Page)

For Any Positive Test List Specimen and Date Collected

Rapid Diagnostic Test ☐ D = Direct Fluorescent Antibody (DFA), O = Other
Specify: ____

	Date Collected Month	Day	Year
1st Specimen: ____			
2nd Specimen: ____			
3rd Specimen: ____			

☐ **Tzanck Smear** Date Collected Month ___ Day ___ Year ___
Result ☐ P = Positive, N = Negative, U = Unknown

For Any Positive Test List Specimen and Date Collected

☐ **Viral Culture**

	Date Collected Month	Day	Year
1st Specimen: ____			
2nd Specimen: ____			
3rd Specimen: ____			

☐ **Polymerase Chain Reaction (PCR)**

	Date Collected Month	Day	Year	Strain Identified
1st Specimen: ____				
2nd Specimen: ____				
3rd Specimen: ____				

W = Wild, V = Vaccine

HOSPITAL DISCHARGE DATA

Discharge Summary Information Available? ☐ Y = Yes, N = No

Varicella Included Among Diagnoses? ☐ Y = Yes, N = No

Discharge Diagnoses (Include ICD-9 Code If Available)

	Diagnosis	ICD-9 Code		Diagnosis	ICD-9 Code
#1:		.	#6:		.
#2:		.	#7:		.
#3:		.	#8:		.
#4:		.	#9:		.
#5:		.	#10:		.

POST-MORTEM EXAM DATA

Post-Mortem Exam Done? ☐ Y = Yes, N = No, U = Unknown

Pathological Evidence of Varicella Noted? ☐ Y = Yes, N = No

If Evidence of Varicella, Significant Findings Related to Varicella-Zoster Virus Infection, by Organ System

	Organ	Findings
#1:		
#2:		
#3:		
#4:		
#5:		

Other: ____

DEATH CERTIFICATE

Death Certificate Available? ☐ Y = Yes, N = No

Varicella Included as One Cause of Death? ☐ Y = Yes, N = No

	Part I: Cause of Death	ICD-9 Code		Part II: Contributing Conditions	ICD-9 Code
#1:		.	#1:		.
#2:		.	#2:		.
#3:		.	#3:		.
#4:		.	#4:		.

SOURCE DATA

Source ☐ C = Close Contact With a Person With Known or Suspected Infection, 10-21 Days Before Rash Onset; U = Unknown

Source Had ☐ S = Shingles, V = Varicella, U = Unknown

Age of Source ☐☐☐ Unk = 999

Age Type ☐ 0 = 0-120 years, 1 = 0-11 months, 2 = 0-52 weeks, 3 = 0-28 days, 9 = Age unknown

Varicella Vaccine History of Source ☐ V = Source Vaccinated, N = Source Not Vaccinated

If Not Vaccinated, Source Had Contraindication to Vaccination? ☐ Y = Yes, N = No, U = Unknown
Specify: ____

Suspected Transmission Setting ☐
1 = Home
2 = School (not College)
3 = College
4 = Work
5 = Church
6 = Military
7 = Perinatal/In Utero
8 = Doctor's Office
9 = Unknown
10 = Hospital, Inpatient
11 = Hospital, ER
12 = Other; Specify: ____

For Transmission Within The Home ☐
A = Transmission From Family Member by Adoption
B = Transmission From Family Member Biologically Related