

Name, Address, Telephone: Home, Work, State Case I.D. Number, Reporting Physician/Nurse/Hospital/Clinic/Lab, Telephone Number

Detach here - Transmit only lower portion if sent to CDC

VARICELLA SURVEILLANCE WORKSHEET

Form Approved OMB No. 0920-0728 Exp. Date 2/28/2011

Reported by: State County

- 1. Date of Birth, 2. Current Age, 3. Age Type, 4. Current Sex, 5. Ethnicity, 6. Race

REPORTING SOURCE

- 7. Date of Report, 8. Earliest Date Reported to County, 9. Earliest Date Reported to State



Department of Health and Human Services Centers for Disease Control and Prevention



CLINICAL

Y=Yes N=No U=Unknown

CONDITION

- 10. Diagnosis Date, 11. Illness Onset Date

SIGNS/SYMPTOMS

- 12. Rash Onset Date, 13. Rash Location, If "Focal," specify dermatome, If "Generalized," first noted

- 14. How many lesions were there in total?, 15. Character of Lesions (with <50) Number of lesions

- 16. Character of Lesions (all categories-1 to >500)

- 17. Did the rash crust?, If "yes," how many days until all the lesions crusted over?, If "no," how many days did the rash last?

- 18. Did the patient have a fever?, 19. Date of Fever Onset, 20. Highest measured temperature, 21. Total number of days with fever, 22. Is patient immunocompromised due to medical condition or treatment?

COMPLICATIONS

- 23. Did the patient visit a healthcare provider during this illness?, 24. Did the patient develop any complications that were diagnosed by a healthcare provider? If "yes": Skin/Soft Tissue Infection, Cerebellitis/Ataxia, Encephalitis, Dehydration, Hemorrhagic Condition, Pneumonia, How diagnosed, Other Complications

- 25. Was the patient treated with acyclovir, famvir, or any licensed antiviral for this illness? If "yes," Name of medication, Start Date, Stop Date

26. Was the patient hospitalized for this illness? If "yes":  Y  N  U

Admission Date

Discharge Date

Total duration of stay in the hospital: \_\_\_\_\_ Days

Hospital Information NAME \_\_\_\_\_

27. Did the patient die from varicella or complications (including secondary infection) associated with varicella? If "yes":  Y  N  U

Date of Death

Autopsy performed?  Y  N  U

Cause of death \_\_\_\_\_

NOTE: Fill out varicella death worksheet.

**LABORATORY**

Y=Yes N=No U=Unknown

28. Was laboratory testing done for varicella? If "yes":  Y  N  U

29. Direct fluorescent antibody (DFA) technique?  Y  N  U

Date of DFA

DFA Result  Positive  Pending  
 Negative  Not Done  
 Indeterminate  Unknown

30. PCR specimen?  Y  N  U

Date of PCR Specimen

Source of PCR specimen: (check all that apply)

Vesicular Swab  Saliva  
 Scab  Blood  
 Tissue Culture  Urine  
 Buccal Swab  Macular Scraping  
 Other \_\_\_\_\_

PCR Result  Positive  Not Done  
 Negative  Pending  
 Indeterminate  Unknown  
 Other \_\_\_\_\_

31. Culture performed?  Y  N  U

Date of Culture Specimen

Culture Result  Positive  Pending  
 Negative  Not Done  
 Indeterminate  Unknown

32. Was other laboratory testing done? If "yes":  Y  N  U

Specify Other Test  Tzanck smear  
 Electron microscopy

Date of Other Test

Other Lab Test Result  Positive (results consistent with varicella infection)  
 Negative  
 Indeterminate  Not Done  
 Pending  Unknown

Test Result Value \_\_\_\_\_

33. Serology performed?  Y  N  U

34. IgM performed? If "yes":  Y  N  U

Type of IgM Test  Capture ELISA  Unknown  
 Indirect ELISA  Other \_\_\_\_\_

Date IgM Specimen Taken

IgM Test Result  Positive  Pending  
 Negative  Not Done  
 Indeterminate  Unknown

Test Result Value \_\_\_\_\_

35. IgG performed? If "yes":  Y  N  U

Type of IgG Test:  Whole Cell ELISA (specify manufacturer): \_\_\_\_\_

gp ELISA (specify manufacturer): \_\_\_\_\_

FAMA  Latex Bead Agglutination  
 Other \_\_\_\_\_

Date of IgG-Acute

IgG-Acute Result  Positive  Pending  
 Negative  Not Done  
 Indeterminate  Unknown

Test Result Value \_\_\_\_\_

Date of IgG-Convalescent

IgG-Conv. Result  Positive  Pending  
 Negative  Not Done  
 Indeterminate  Unknown

Test Result Value \_\_\_\_\_

36. Were the clinical specimens sent to CDC for genotyping (molecular typing)? If "yes":  Y  N  U

Date sent for genotyping

37. Was specimen sent for strain (wild- or vaccine-type) identification?  Y  N  U

Strain Type  Wild Type Strain  
 Vaccine Type Strain  
 Unknown

**VACCINE INFORMATION**

Y=Yes N=No U=Unknown

38. Did the patient receive varicella-containing vaccine?  Y  N  U  
 If "no," reason:
- Born outside the United States
  - Lab evidence of previous disease
  - MD diagnosis of previous disease
  - Medical contraindication
  - Never offered vaccine
  - Parent/patient forgot to vaccinate
  - Parent/patient refusal
  - Parent/patient report of previous disease
  - Philosophical objection
  - Religious exemption
  - Under age for vaccination
  - Other \_\_\_\_\_
  - Unknown

39. Number of doses received on or after first birthday: \_\_\_\_\_ Doses
40. If patient is  $\geq 6$  years old and received one dose on or after 6th birthday but never received second dose, what is the reason?
- Born outside the United States
  - Lab evidence of previous disease
  - MD diagnosis of previous disease
  - Medical contraindication
  - Never offered vaccine
  - Parent/patient forgot to vaccinate
  - Parent/patient refusal
  - Parent/patient report of previous disease
  - Philosophical objection
  - Religious exemption
  - Other \_\_\_\_\_
  - Unknown

**VACCINATION RECORD**

Vaccination Date(s)	Vaccine Type	Manufacturer	Lot Number
___/___/___			
___/___/___			
___/___/___			
___/___/___			
___/___/___			

**EPIDEMIOLOGIC**

Y=Yes N=No U=Unknown

41. Case Investigation Start Date  MONTH  DAY  YEAR
42. Has this patient ever been diagnosed with varicella before?  Y  N  U  
 If "yes":  
 Age at Diagnosis   
 Age Type  Years  Days  Months  Hours  Weeks  Unknown
43. Previous case diagnosed by:  Physician/Health Care Provider  Parent/Friend  Other \_\_\_\_\_
44. Where was the patient born (country)? \_\_\_\_\_
45. Is this case epi-linked to another confirmed or probable case?  Y  N  U  
 If "yes," epi-linked to:  Confirmed Varicella Case  Probable Varicella Case  Herpes Zoster Case
46. Transmission Setting (Setting of Exposure)
- Athletics  Hospital Outpatient Clinic
  - College  Hospital Ward
  - Community  International Travel
  - Correctional Facility  Military
  - Daycare  Doctor's Office
  - Doctor's Office  Place of Worship
  - Home  School
  - Hospital ER  Work
  - Other \_\_\_\_\_  Unknown

47. Is this case a healthcare worker?  Y  N  U
48. Is this case part of an outbreak of 5 or more cases?  Y  N  U  
 If "yes":  
 Outbreak Name: \_\_\_\_\_
49. Case Status:  Confirmed  Probable  Suspect  Not a Case  Unknown
50. MMWR Week: \_\_\_\_\_
51. MMWR Year: \_\_\_\_\_

**PREGNANT WOMEN**

52. If the case is female, is/was she pregnant during this varicella illness?  Y  N  U  
 If "yes":  
 Number of weeks gestation at onset of illness (1-45 weeks): \_\_\_\_\_ Weeks  
 Trimester at Onset of Illness  1st Trimester  2nd Trimester  3rd Trimester
53. General Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_