

Varicella Surveillance Worksheet

| | | | |
|--|---------------------------------|--------------|----------------------------|
| NAME | ADDRESS (Street and No.) | Phone | Hospital Record No. |
| (last) _____ | (first) _____ | _____ | _____ |
| This information will not be sent to CDC | | | |

| | | |
|---|---------------------------|---------------------------------------|
| REPORTING SOURCE TYPE | NAME _____ | SUBJECT ADDRESS CITY _____ |
| <input type="checkbox"/> physician <input type="checkbox"/> PH clinic | ADDRESS _____ | SUBJECT ADDRESS STATE _____ |
| <input type="checkbox"/> nurse <input type="checkbox"/> laboratory | ZIP CODE _____ | SUBJECT ADDRESS COUNTY _____ |
| <input type="checkbox"/> hospital <input type="checkbox"/> other clinic | PHONE (____) _____ | SUBJECT ADDRESS ZIP CODE _____ |
| <input type="checkbox"/> other source type _____ | | LOCAL SUBJECT ID _____ |

CASE INFORMATION

| | | | |
|--|--|---|------------------------------|
| Date of Birth _____ <small>month day year</small> | Sex M=male F=female U=unknown <input type="checkbox"/> | Ethnic Group H=Hispanic/Latino N=not Hispanic/Latino O=other _____ U=unknown | |
| Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not asked Refused to answer <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown _____ | | | |
| Birth Place _____ | Other Birth Place _____ | Country of Usual Residence _____ | |
| Age at Case Investigation _____ | Age Unit* _____ | Reporting County _____ | Reporting State _____ |
| Date Reported _____ <small>month day year</small> | Date First Reported to PHD _____ <small>month day year</small> | National Reporting Jurisdiction _____ | |
| Earliest Date Reported to County _____ <small>month day year</small> | | Earliest Date Reported to State _____ <small>month day year</small> | |
| Case Class Status <input type="checkbox"/> Suspected <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> Unknown <input type="checkbox"/> Not a case | | Case Investigation Start Date _____ <small>month day year</small> | |
| Case Investigation Status Code <input type="checkbox"/> approved <input type="checkbox"/> closed <input type="checkbox"/> deleted <input type="checkbox"/> in progress <input type="checkbox"/> notified <input type="checkbox"/> other _____ <input type="checkbox"/> rejected <input type="checkbox"/> reviewed <input type="checkbox"/> suspended <input type="checkbox"/> unknown | | | |

CLINICAL INFORMATION

| | | | |
|---|---|---|---|
| Hospitalized? Y=yes N=no U=unknown <input type="checkbox"/> | Hospital Admission Date _____ <small>month day year</small> | Hospital Discharge Date _____ <small>month day year</small> | |
| Hospital Stay Duration 0-998 <input type="text"/> <input type="text"/> <input type="text"/> <small>999=unknown (days)</small> | Illness Onset Date _____ <small>month day year</small> | Illness End Date _____ <small>month day year</small> | |
| Illness Duration _____ | Illness Duration Units* _____ | Date of Diagnosis _____ <small>month day year</small> | Pregnancy Status Y=yes N=no U=unknown <input type="checkbox"/> |
| REASON FOR HOSPITALIZATION | <input type="checkbox"/> Varicella related complications <input type="checkbox"/> Administration of IV treatment <input type="checkbox"/> Isolation <input type="checkbox"/> Non-varicella hospitalization <input type="checkbox"/> Observation <input type="checkbox"/> Other _____ <input type="checkbox"/> Severe varicella presentation <input type="checkbox"/> Unknown | | |
| Rash Onset Date _____ <small>month day year</small> | Rash Duration _____ (days) | Was the rash generalized? Y=yes N=no U=unknown <input type="checkbox"/> | |
| BODY REGIONS OF RASH (if rash not generalized) | <input type="checkbox"/> Arm, hand, torso, back | <input type="checkbox"/> Leg | <input type="checkbox"/> Upper mid-abdomen/flank |
| | <input type="checkbox"/> Head/face with eye involvement | <input type="checkbox"/> Neck/shoulder | <input type="checkbox"/> Other (specify) _____ |
| | <input type="checkbox"/> Head/face without eye involvement | <input type="checkbox"/> Pelvis/groin/buttocks/hip | <input type="checkbox"/> Unknown |
| Total Number of Lesions <input type="checkbox"/> <50 <input type="checkbox"/> 50-249 <input type="checkbox"/> 50-500 <input type="checkbox"/> 250-499 <input type="checkbox"/> >500 <input type="checkbox"/> Unknown | | If <50 lesions, how many? <input type="text"/> <input type="text"/> | |
| Character of Lesions <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular <input type="checkbox"/> other _____ <input type="checkbox"/> unknown | | Were the lesions hemorrhagic? Y=yes N=no U=unknown <input type="checkbox"/> | |
| Were the lesions itchy? Y=yes N=no U=unknown <input type="checkbox"/> | | Did the lesions appear in crops/waves? Y=yes N=no U=unknown <input type="checkbox"/> | |
| Did the lesions crust/scab over? Y=yes N=no U=unknown <input type="checkbox"/> | | Is patient immunocompromised? Y=yes N=no U=unknown <input type="checkbox"/> | |
| If patient immunocompromised, then immunocompromised-associated condition or treatment: _____ | | | |
| Did patient visit a healthcare provider during this illness? Y=yes N=no U=unknown <input type="checkbox"/> | | Fever ? Y=yes N=no U=unknown <input type="checkbox"/> | |
| Fever Onset Date _____ <small>month day year</small> | Fever Duration _____ (days) | Highest Temperature _____ . _____ | Temperature Units <input type="checkbox"/> °Cel <input type="checkbox"/> °F |

*UNITS a=year h=hour mo=month wk=week d=day min=minute s=second UNK=unknown

COMPLICATIONS

| TYPE OF COMPLICATIONS | Y N U | | | Y N U | | | Y N U D | | | | | | |
|-----------------------|-----------------------|--|--|-------|----------------------------|--|---------|--|----------------------------------|--|--|--|--|
| | cerebellitis/ataxia | | | | skin/soft tissue infection | | | | pneumonia | | | | |
| | dehydration | | | | other _____ | | | | Chest X-ray for pneumonia | | | | |
| | hemorrhagic condition | | | | varicella encephalitis | | | | Y=yes N=no U=unknown D=not done | | | | |

Subject's death from this illness or complications of this illness? Y=yes N=no U=unknown **Deceased Date** ____-____-____
month day year

TREATMENT

Antiviral medication? Y=yes N=no U=unknown **Treatment Start Date** ____-____-____
month day year **Treatment Duration** ____ (days)

Medication received: acyclovir famciclovir valacyclovir other _____ unknown

LABORATORY TESTING

VPD Lab Message Reference Laboratory _____ **VPD Lab Message Patient Identifier** _____ **VPD Lab Message Specimen Identifier** _____

Was laboratory testing done to confirm the diagnosis? Y=yes N=no U=unknown

Was case laboratory-confirmed? Y=yes N=no U=unknown **Was a specimen sent to CDC for testing?** Y=yes N=no U=unknown

| Test Type | Test Result | Date Specimen Collected <small>[mm dd yyyy]</small> | Test Result Quantitative | Result Units | Specimen Source | Date Specimen Sent to CDC <small>[mm dd yyyy]</small> | Date Specimen Analyzed <small>[mm dd yyyy]</small> | Performing Laboratory Type |
|----------------------|-------------|--|--------------------------|--------------|-----------------|--|---|----------------------------|
| IgM | | _____ | | | | _____ | _____ | |
| IgG avidity | | _____ | | | | _____ | _____ | |
| IgG (acute) | | _____ | | | | _____ | _____ | |
| IgG (conv) | | _____ | | | | _____ | _____ | |
| IgG EIA | | _____ | | | | _____ | _____ | |
| unspecified serology | | _____ | | | | _____ | _____ | |
| Culture | | _____ | | | | _____ | _____ | |
| DFA | | _____ | | | | _____ | _____ | |
| PCR | | _____ | | | | _____ | _____ | |
| Genotype | | _____ | | | | _____ | _____ | |
| Other | | _____ | | | | _____ | _____ | |
| Strain ID | | _____ | | | | _____ | _____ | |
| Unknown | | _____ | | | | _____ | _____ | |

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|-----------------------|-------------------|-----------------------|-------------------|-----------|----------------|-------|---------------|-----------|---------|-----------|----------|----------|---------|------------------|--------------------|----------|-------------------|-----------|----------------|--|---|-----------|------------------|----------------|----------------------|---------------------|-------------------|---------|-----------|
| <p style="text-align: center;">Test Results Codes</p> <p>P=positive N=negative X=not done I=Indeterminate E=pending O=other (specify) IN=inadequate NS=no significant rise in IgG PS=significant rise in IgG U=unknown V=vaccine type strain W=wild type strain</p> | <p style="text-align: center;">Specimen Source Codes</p> <table style="width: 100%; font-size: small;"> <tr><td>1=blood</td><td>8=other (specify)</td><td>15=swab (skin lesion)</td></tr> <tr><td>2=bronchoalveolar</td><td>9=unknown</td><td>16=throat swab</td></tr> <tr><td>3=CSF</td><td>10=NP washing</td><td>17=tissue</td></tr> <tr><td>4=crust</td><td>11=saliva</td><td>18=urine</td></tr> <tr><td>5=lesion</td><td>12=scab</td><td>19=vesicle fluid</td></tr> <tr><td>6=macular scraping</td><td>13=serum</td><td>20=vesicular swab</td></tr> <tr><td>7=NP swab</td><td>14=skin lesion</td><td></td></tr> </table> | 1=blood | 8=other (specify) | 15=swab (skin lesion) | 2=bronchoalveolar | 9=unknown | 16=throat swab | 3=CSF | 10=NP washing | 17=tissue | 4=crust | 11=saliva | 18=urine | 5=lesion | 12=scab | 19=vesicle fluid | 6=macular scraping | 13=serum | 20=vesicular swab | 7=NP swab | 14=skin lesion | | <p style="text-align: center;">Performing Laboratory Type</p> <table style="width: 100%; font-size: small;"> <tr><td>1=CDC lab</td><td>2=commercial lab</td></tr> <tr><td>3=hospital lab</td><td>4=other clinical lab</td></tr> <tr><td>5=public health lab</td><td>6=VPD testing lab</td></tr> <tr><td>8=other</td><td>9=unknown</td></tr> </table> | 1=CDC lab | 2=commercial lab | 3=hospital lab | 4=other clinical lab | 5=public health lab | 6=VPD testing lab | 8=other | 9=unknown |
| 1=blood | 8=other (specify) | 15=swab (skin lesion) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2=bronchoalveolar | 9=unknown | 16=throat swab | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3=CSF | 10=NP washing | 17=tissue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4=crust | 11=saliva | 18=urine | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5=lesion | 12=scab | 19=vesicle fluid | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6=macular scraping | 13=serum | 20=vesicular swab | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7=NP swab | 14=skin lesion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1=CDC lab | 2=commercial lab | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3=hospital lab | 4=other clinical lab | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5=public health lab | 6=VPD testing lab | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8=other | 9=unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

VACCINATION HISTORY

VACCINATED (has the case-patient ever received varicella-containing vaccine)? Y=yes N=no U=unknown

Number of vaccine doses received on or after first birthday? 0-6 99=unknown (doses)

Number of vaccine doses received prior to illness onset? 0-6 99=unknown (doses)

Date of last vaccine dose prior to illness onset? _____ (mm/dd/yyyy)

Was case-patient vaccinated as recommended by the ACIP? Y=yes N=no U=unknown

| Vaccine Type | Vaccination Date <small>month day year</small> | Vaccine Manuf | Vaccine Lot Number | Vaccine Expiry Date <small>month day year</small> | National Drug Code | Vaccination Record Identifier | Vaccine Event Information Source | Vaccine Dose Number |
|--------------|---|---------------|--------------------|--|--------------------|-------------------------------|----------------------------------|---------------------|
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

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|---|---|---|
| <p style="text-align: center;">VACCINE TYPE CODES</p> <p>M=measles/mumps/rubella/varicella [MMRV] V = varicella vaccine O = other (specify) _____ U = unknown</p> | <p style="text-align: center;">VACCINE MANUFACTURER CODES</p> <p>M = Merck O = other (specify) _____ U = unknown</p> | <p style="text-align: center;">VACCINE EVENT INFORMATION SOURCE CODES</p> <p>00= new immunization record 01= historical information, source unidentified 02= historical information, other provider 05= historical information, other registry OTH= other _____ 06= historical information, birth certificate UNK= unknown 07= historical information, school record 08= historical information, public agency 09= historical information, patient or parent recall 10= historical information, patient or parent written record</p> |
|---|---|---|

REASON NOT VACCINATED PER ACIP

| | | |
|--------------------------------------|---|--|
| 1 = religious exemption | 6 = too young | 11 = vaccine record incomplete/unavailable |
| 2 = medical contraindication | 7 = parent/patient refusal | 12 = parent/patient report of previous disease |
| 3 = philosophical objection | 8 = other _____ | 13 = parent/patient unaware of recommendation |
| 4 = lab evidence of previous disease | 9 = unknown | 14 = missed opportunity |
| 5 = MD diagnosis of previous disease | 10 = parent/patient forgot to vaccinate | 15 = foreign visitor <input type="text"/> <input type="text"/> |
| | | 16 = immigrant |

EPIDEMIOLOGIC

Has patient been diagnosed with varicella before? Y=yes N=no U=unknown **Age at previous diagnosis?** _____ **Age Units**[†] _____

Previous case was diagnosed by: Parent Physician/Healthcare provider Other _____ Unknown

If case pregnant at illness onset, weeks gestation? **If case pregnant at illness onset, what was trimester of gestation?**

Is case-patient a healthcare worker? Y=yes N=no U=unknown **Epi-linked to a confirmed or probable case?** Y=yes N=no U=unknown

If epi-linked, type of case: confirmed varicella probable varicella herpes zoster unknown **Transmission Mode** _____

Transmission Setting 1=day care 2=school 3=doctor's office 4=hospital ward 5=hospital ER 6=hospital outpatient clinic 7=home 8=other _____ 9=unknown
10=college 11=military 12=correctional facility 13=place of worship 14=international travel 15=community 16=work 17=athletics

[†]UNITS a=year mo=month w=week d=day UNK=unknown

EXPOSURE

Outbreak Related? Y=yes N=no U=unknown **Outbreak Name** _____ **COUNTRY of Exposure** _____

STATE/PROVINCE of Exposure _____ **COUNTY of Exposure** _____ **CITY of Exposure** _____

Varicella Case Investigation Supplemental Questionnaire

| | |
|-----------------------------|------------------------|
| Patient name (Last, First): | Patient Date of Birth: |
|-----------------------------|------------------------|

| |
|---|
| Epidemiologic Information |
| Did the patient have contact with another person with chickenpox or shingles rash illness 28 days prior to symptom onset? Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, specify type contact name and relationship to case-patient (if available): _____ |
| Did the patient attend day care* or school while infectious (e.g., 2 days before rash onset until all the lesions crusted over)? Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, specify name of facility, location, and phone number (if available): _____ <small>*Day care is defined as a supervised group of 2 or more unrelated children for at least 4 hours per week</small> |
| Does the patient reside in a residential institution? Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, specify name of facility, location, and phone number (if available): _____ |
| Does the patient have contact with persons who may be at high risk for complications from varicella disease because of their age or an underlying condition (e.g., immunocompromised persons, cancer patients, pregnant women, neonates whose mothers are not immune) while infectious? Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, provide further specification: _____ |

Household and close contacts (provide information on any additional contacts on a separate sheet)

| Name | DOB | Relationship to case | Household Member? (Y, N) | Evidence of immunity to varicella or Vaccination History (dates) | High-risk due to age or health condition? (Y, N) | VZIG Recommended? (Y, N, U and date if Y) |
|------|-----|----------------------|-----------------------------|---|---|--|
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Notes:

Completed by: _____ Phone: _____ Date: _____