

Name, Address, Telephone, Reporting Physician, Telephone Number, State Case I.D. Number

Detach here - Transmit only lower portion if sent to CDC

VARICELLA SURVEILLANCE WORKSHEET

Form Approved OMB No. 0920-0007 Exp. Date 7/31/2007

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



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: Macules, Papules, Vesicles

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

- Mostly macular/papular, Mostly vesicular, Hemorrhagic, Itchy, Scabs, Crops/waves

- 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? Skin/Soft Tissue Infection, Cerebellitis/Ataxia, Encephalitis, Dehydration, Hemorrhagic Condition, Pneumonia

- 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
MONTH DAY YEAR

Discharge Date
MONTH DAY YEAR

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
MONTH DAY YEAR

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
MONTH DAY YEAR

DFA Result Positive Pending
 Negative Not Done
 Indeterminate Unknown

30. PCR specimen? Y N U

Date of PCR Specimen
MONTH DAY YEAR

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
MONTH DAY YEAR

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
MONTH DAY YEAR

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
MONTH DAY YEAR

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
MONTH DAY YEAR

IgG-Acute Result Positive Pending
 Negative Not Done
 Indeterminate Unknown

Test Result Value _____

Date of IgG-Convalescent
MONTH DAY YEAR

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
MONTH DAY YEAR

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 >=13 years old and received one dose on or after 13th 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. 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 Place of Worship
 - Doctor's Office School
 - Home Hospital ER
 - 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: _____

