For Local Use Only

VARICELLA SURVEILLANCE WORKSHEET

Name ______________________ (LAST / FIRST / MIDDLE) State Case I.D. Number __________

Current Address ______________________ (NUMBER / STREET / APT. NUMBER)
______________________ (CITY / COUNTY / STATE ZIP CODE)

Telephone: Home __________ (AREA CODE + 7 DIGITS) Work __________ (AREA CODE + 7 DIGITS)

Reporting Physician/ Nurse/Hospital/ Clinic/Lab __________
__________ ADDRESS

Telephone Number __________ (AREA CODE + 7 DIGITS)

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** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)
2. **Current Age** ☐☐☐
3. **Age Type** ☐ Years ☐ Days ☐ Hours ☐ Months ☐ Weeks ☐ Unknown
4. **Current Sex** ☐ Male ☐ Female ☐ Unknown
5. **Ethnicity** ☐ Hispanic ☐ Not Hispanic ☐ Unknown
6. **Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown

REPORTING SOURCE

7. **Date of Report** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)
8. **Earliest Date Reported to County** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)
9. **Earliest Date Reported to State** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

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

CLINICAL

Y=Yes N No U Unknown

CONDITION

10. **Diagnosis Date** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)
11. **Illness Onset Date** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

SIGNS/SYMPTOMS

12. **Rash Onset Date** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)
13. **Rash Location** ☐ Generalized ☐ Focal ☐ Unknown

If "Focal," specify dermatome: __________

If "Generalized," first noted: *(check all that apply)*
☐ Face/Head ☐ Legs ☐ Trunk ☐ Arms ☐ Inside Mouth ☐ Other *(specify)* __________

14. **How many lesions were there in total?**
☐ <50 ☐ 50–249 ☐ 250–499 ☐ >500

15. **Character of Lesions (with <50)** Number of lesions: ______
Macules (flat) present: ☐ Y ☐ N ☐ U Number: ______
Papules (raised) present: ☐ Y ☐ N ☐ U Number: ______
Vesicles (fluid) present: ☐ Y ☐ N ☐ U Number: ______

16. **Character of Lesions (all categories—1 to >500)**
Mostly macular/papular ☐ Y ☐ N ☐ U
Mostly vesicular ☐ Y ☐ N ☐ U
Hemorrhagic ☐ Y ☐ N ☐ U
Itchy ☐ Y ☐ N ☐ U
Scabs ☐ Y ☐ N ☐ U
Crops/waves ☐ Y ☐ N ☐ U

17. **Did the rash crust?** ☐ Y ☐ N ☐ U

If "yes," how many days until all the lesions crusted over? ______ Days

If "no," how many days did the rash last? ______ Days

18. **Did the patient have a fever?** ☐ Y ☐ N ☐ U
19. **Date of Fever Onset** ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)
20. **Highest measured temperature:** ______ °F / °C (CIRCLE ONE)
21. **Total number of days with fever:** ______ Days
22. **Is patient immunocompromised due to medical condition or treatment?** ☐ Y ☐ N ☐ U

(If yes, specify) __________

COMPLICATIONS

23. **Did the patient visit a healthcare provider during this illness?** ☐ Y ☐ N ☐ U
24. **Did the patient develop any complications that were diagnosed by a healthcare provider? If "yes":** ☐ Y ☐ N ☐ U

Skin/Soft Tissue Infection ☐ Y ☐ N ☐ U
Cerebellitis/Ataxia ☐ Y ☐ N ☐ U
Encephalitis ☐ Y ☐ N ☐ U
Dehydration ☐ Y ☐ N ☐ U
Hemorrhagic Condition ☐ Y ☐ N ☐ U
Pneumonia ☐ Y ☐ N ☐ U
How diagnosed: ☐ X-ray ☐ MD ☐ U
Other Complications ☐ Y ☐ N ☐ U

(Specify) __________

25. **Was the patient treated with acyclovir, famvir, or any licensed antiviral for this illness? If "yes,"** ☐ Y ☐ N ☐ U

Name of medication: __________

Start Date ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

Stop Date ☐☐ ☐☐ ☐☐☐☐ (MONTH DAY YEAR)

CS118977

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-0007)

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
- ☐ Negative
- ☐ Indeterminate
- ☐ Pending
- ☐ Not Done
- ☐ Unknown

30. **PCR specimen?** ☐ Y ☐ N ☐ U

Date of PCR Specimen MONTH / DAY / YEAR

Source of PCR specimen: *(check all that apply)*
- ☐ Vesicular Swab
- ☐ Scab
- ☐ Tissue Culture
- ☐ Buccal Swab
- ☐ Other ____________________
- ☐ Saliva
- ☐ Blood
- ☐ Urine
- ☐ Macular Scraping

PCR Result
- ☐ Positive
- ☐ Negative
- ☐ Indeterminate
- ☐ Other ____________________
- ☐ Not Done
- ☐ Pending
- ☐ Unknown

31. **Culture performed?** ☐ Y ☐ N ☐ U

Date of Culture Specimen MONTH / DAY / YEAR

Culture Result
- ☐ Positive
- ☐ Negative
- ☐ Indeterminate
- ☐ Pending
- ☐ Not Done
- ☐ 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
- ☐ Pending
- ☐ Not Done
- ☐ Unknown

Test Result Value ____________________

33. **Serology performed?** ☐ Y ☐ N ☐ U

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

Type of IgMTest
- ☐ Capture ELISA
- ☐ Indirect ELISA
- ☐ Unknown
- ☐ Other ____________________

Date IgM Specimen Taken MONTH / DAY / YEAR

IgM Test Result
- ☐ Positive
- ☐ Negative
- ☐ Indeterminate
- ☐ Pending
- ☐ Not Done
- ☐ 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
- ☐ Negative
- ☐ Indeterminate
- ☐ Pending
- ☐ Not Done
- ☐ Unknown

Test Result Value ____________________

Date of IgG-Convalescent MONTH / DAY / YEAR

IgG-Conv. Result
- ☐ Positive
- ☐ Negative
- ☐ Indeterminate
- ☐ Pending
- ☐ Not Done
- ☐ 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 >=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

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
- ☐ College
- ☐ Community
- ☐ Correctional Facility
- ☐ Daycare
- ☐ Doctor's Office
- ☐ Home
- ☐ Hospital ER
- ☐ Other ______
- ☐ Hospital Outpatient Clinic
- ☐ Hospital Ward
- ☐ International Travel
- ☐ Military
- ☐ Place of Worship
- ☐ School
- ☐ Work
- ☐ 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:** ______