For Local Use Only

VARICELLA SURVEILLANCE WORKSHEET

Name _____ State Case I.D. Number _____
LAST / FIRST / MIDDLE

Current Address _____
NUMBER / STREET / APT. NUMBER

_____
CITY / COUNTY / STATE ZIP CODE

Telephone: Home _____ Work _____
AREA CODE + 7 DIGITS AREA CODE + 7 DIGITS

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

_____
CITY / STATE / ZIP

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:** _____
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)

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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 IgMTest
☐ 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 >=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
- ☐ Months
- ☐ Weeks
- ☐ Days
- ☐ Hours
- ☐ 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:**