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

Telephone Number _____
AREA CODE + 7 DIGITS

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** ☐☐ (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)

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)

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