### VARICELLA SURVEILLANCE WORKSHEET

**Recommended by:** [State Case I.D. Number __________]  
**Reporting Physician/Nurse/Hospital/Clinic/Lab:**
**Address:**
**Telephone Number:**
**Date Reported:**

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#### CLINICAL

**CONDITION**

10. Diagnosis Date: [Month] [Day] [Year]  
11. Illness Onset Date: [Month] [Day] [Year]

#### SIGNS/SYMTOMS

12. Rash Onset Date: [Month] [Day] [Year]  
13. Rash Location:  
   - Generalized
   - Focal
   - Unknown

   If “Focal,” specify dermatome:  
   - 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):  
   - 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?  
   - 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

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? [Y] [N] [U]
   - Skin/Soft Tissue Infection
   - Cerebellitis/Ataxia
   - Encephalitis
   - Dehydration
   - Hemorrhagic Condition
   - Pneumonia
   - 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? [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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   Discharge Date ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   Total duration of stay in the hospital: ______ Days
   Hospital Information ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

27. Did the patient die from varicella or complications (including secondary infection) associated with varicella? If “yes”:
   ☐ Y ☐ N ☐ U
   Date of Death ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   Autopsy performed? ☐ Y ☐ N ☐ U
   Cause of death ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

   NOTE: Fill out varicella death worksheet.

LABORATORY

28. Was laboratory testing done for varicella? If “yes”:
   ☐ Y ☐ N ☐ U

29. Direct fluorescent antibody (DFA) technique?
   ☐ Y ☐ N ☐ U
   Date of DFA ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   DFA Result ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown

30. PCR specimen?
   ☐ Y ☐ N ☐ U
   Date of PCR Specimen ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   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 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   Culture Result ☐ Positive ☐ Not Pending ☐ Negative ☐ Not Done
   ☐ Indeterminate ☐ Unknown ☐ Other

32. Was other laboratory testing done? If “yes”:
   ☐ Y ☐ N ☐ U
   Specify ☐ Tzanck smear
   Other Test ☐ Electron microscopy
   Date of Other Test ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   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?
   ☐ Y ☐ N ☐ U
   If “yes”:
   Type of IgM Test ☐ Capture ELISA ☐ Unknown
   ☐ Indirect ELISA ☐ Other
   Date IgM Specimen Taken ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   IgM Test Result ☐ Positive ☐ Pending ☐ Negative ☐ Not Done
   ☐ Indeterminate ☐ Unknown
   Test Result Value ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

35. IgG performed?
   ☐ Y ☐ N ☐ U
   If “yes”:
   Type of IgG Test:
   ☐ Whole Cell ELISA (specify manufacturer):
   ☐ gp ELISA (specify manufacturer):
   ☐ FAMA ☐ Latex Bead Agglutination
   ☐ Other
   Date of IgG-Acute ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   IgG-Acute Result ☐ Positive ☐ Pending ☐ Negative ☐ Not Done
   ☐ Indeterminate ☐ Unknown
   Test Result Value ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   Date of IgG-Conv. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   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)?
   ☐ Y ☐ N ☐ U
   If “yes”:
   Date sent for genotyping ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

37. Was specimen sent for strain identification?
   ☐ Y ☐ N ☐ U
   Strain Type ☐ Wild Type Strain
   ☐ Vaccine Type Strain ☐ Unknown
   Test Result Value ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
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

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 _________

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: ____________________________
   Case Status: □ Confirmed
   □ Probable
   □ Suspect
   □ Not a Case
   □ Unknown

50. MMWR Week: ____________________________

51. MMWR Year: ____________________________

52. If the case is female, is/was she pregnant during this varicella illness? □ Y □ N □ U
   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: ____________________________
   __________________________________________
   __________________________________________