

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. 0920-0728
 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":
 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,"
 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 ☐ 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-Convaescent
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

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 ☐ Hospital Outpatient Clinic
☐ College ☐ Hospital Ward
☐ Community ☐ International Travel
☐ Correctional Facility ☐ Military
☐ Daycare ☐ Place of Worship
☐ Doctor's Office ☐ School
☐ Home ☐ 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: _____