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
- ☐ Saliva
- ☐ Blood
- ☐ Urine
- ☐ Macular Scraping
- ☐ Other _____

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 IgM Test
- ☐ 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