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# VZV Specimen Collection Form

Unique Identifier Assigned by CDC

## Patient Information

*Name (Last, First): _____

*Date of Birth: _____ or Age (yrs): _____

Sex: ☐ Male ☐ Female

Address: _____

City/State/Zip: _____

Phone: _____ _____

## Provider Information

(Results will be sent to provider)

*Name: _____

*Institution: _____

Address: _____

City/State/Zip: _____

*Phone: _____ Fax: _____

*Email: _____

## Specimen Information

*Date Collected: _____

***Source of Specimen (check only 1 type for each specimen):**

**Specimen 1:**

- ☐ Vesicle (fluid-filled blister)
- ☐ Macule/Papule (red, raised lesion)
- ☐ Crust/Scab
- ☐ Other Skin Specimen
- ☐ Blood
- ☐ Cerebrospinal Fluid
- ☐ Other (specify below):

_____

**Specimen 2:**

- ☐ Vesicle (fluid-filled blister)
- ☐ Macule/Papule (red, raised lesion)
- ☐ Crust/Scab
- ☐ Other Skin Specimen
- ☐ Blood
- ☐ Cerebrospinal Fluid
- ☐ Other (specify below):

_____

If there are additional specimens, please indicate source of each specimen on next page.*

**Reason for Specimen Submission:**

- ☐ Suspected vaccine adverse event (including verification of vaccine strain or transmission of vaccine virus)
- ☐ Lab confirmation of varicella or zoster diagnosis
- ☐ Determine patient's susceptibility
- ☐ Other (specify below):

_____

If an adverse event is suspected, has a VAERS report been submitted?

☐ Yes - VAERS number: _____ ☐ No

In the week prior to specimen collection, did the patient take oral antivirals (i.e., acyclovir, famciclovir, or valacyclovir)?

☐ Yes ☐ No ☐ Unknown

## Clinical History

**Date of Rash Onset:** _____

**Rash Type (check all that apply):**

☐ Vesicles (fluid) ☐ Macule/Papule (red, raised lesion)

☐ Other (describe): _____

**Total # Lesions:** ☐ <50 ☐ 50-249 ☐ 250-500 ☐ >500 ☐ Unknown

**Clinical Diagnosis:**

- ☐ Varicella (Chickenpox)
- ☐ Zoster (Shingles) Body site/Dermatome: _____
- ☐ Other (specify): _____
- ☐ Unknown

**History of Chickenpox/Shingles:**

☐ Yes chickenpox - Age: _____ ☐ No chickenpox ☐ Unknown

☐ Yes shingles - Age: _____ ☐ No shingles ☐ Unknown

**Conditions/Medications/Treatment:**

Does the patient have any current chronic medical condition that depresses the immune system (e.g., cancer, leukemia, HIV/AIDS, organ transplant)?

☐ Yes ☐ No ☐ Unknown

If yes, specify: _____

Did the patient take **steroid(s)** (i.e., oral ≥2mg/kg of body weight or total of ≥20mg/day of prednisone or equivalent for persons >10kg and administered for ≥2 weeks) or **immunosupressant(s)** during the month prior to rash onset?

☐ Yes ☐ No ☐ Unknown

Was the patient prescribed **antivirals** (i.e., oral acyclovir, famiciclovir, or valavyclovir) to treat this rash?

☐ Yes ☐ No ☐ Unknown

If yes, dates of treatment: _____

## VZV Vaccine Information

Has the patient received varicella-containing vaccine?

☐ Yes ☐ No ☐ Unknown

Dose 1: Date: _____ Lot #: _____

Vaccine Type: ☐ Varivax ☐ MMRV ☐ Zostavax

Dose 2: Date: _____ Lot #: _____

Vaccine Type: ☐ Varivax ☐ MMRV ☐ Zostavax

Note: Contact CDC before sending specimens at 404-639-0066 or 404-639-2192.

*** See Page 2 for additional specimen handling instructions and provide additional information.**



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## Additional Clinical or Laboratory Testing Information:

**Additional Clinical Information:** _____

_____

_____

**Please specify any other lab work performed:** _____

_____

_____

_____

## Additional Specimen Information:

**Source of Specimen (check 1 type for each specimen):**

**Specimen 3:**
- ☐ Vesicle (fluid-filled blister)
- ☐ Macule/Papule (red, raised lesion)
- ☐ Crust/Scab
- ☐ Other Skin Specimen
- ☐ Blood
- ☐ Cerebrospinal Fluid
- ☐ Other (specify below):

_____

**Specimen 4:**
- ☐ Vesicle (fluid-filled blister)
- ☐ Macule/Papule (red, raised lesion)
- ☐ Crust/Scab
- ☐ Other Skin Specimen
- ☐ Blood
- ☐ Cerebrospinal Fluid
- ☐ Other (specify below):

_____

**Specimen 5:**
- ☐ Vesicle (fluid-filled blister)
- ☐ Macule/Papule (red, raised lesion)
- ☐ Crust/Scab
- ☐ Other Skin Specimen
- ☐ Blood
- ☐ Cerebrospinal Fluid
- ☐ Other (specify below):

_____

**Specimen 6:**
- ☐ Vesicle (fluid-filled blister)
- ☐ Macule/Papule (red, raised lesion)
- ☐ Crust/Scab
- ☐ Other Skin Specimen
- ☐ Blood
- ☐ Cerebrospinal Fluid
- ☐ Other (specify below):

_____

**MAIL FORM AND SPECIMEN TO:**

CDC SMB/STAT ATTN: National VZV Laboratory 1600 Clifton Road, NE Atlanta, GA 30333
Tel: (404) 639-0066 or (404) 639-2192 Fax: (404) 639-4056 E-mail: dss1@cdc.gov or kjr7@cdc.gov

Specimens submitted to CDC for testing must also be accompanied by the CDC Specimen Submission Form (CDC 50.34), which can be found at http://www.cdc.gov/laboratory/specimen-submission/form.html. Please affix the UN3373 label (biological substance, category B) to the outer package.

**Additional Instructions:**

1. Information on specimen collection, shipment, and handling can be found online at:
   http://www.cdc.gov/shingles/lab-testing/index.html
2. Label each specimen with specimen number (corresponding to information provided on this form i.e., "Specimen 1") and the source of the specimen (e.g., vesicle, maculepapule, etc.)
3. Place each specimen collected from different lesions in a separate labeled tube or container.
4. Please indicate if you have already notified your state or local health department about this case:
   ☐ Yes ☐ No



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