### VARICELLA SURVEILLANCE WORKSHEET

**Reported by:**

- **State:** 77966-0
- **County:** 77967-0

**Varicella Surveillance**

**Reporting Physician/Nurse/Hospital/Clinic/Lab:**

- **Name:**
- **Address:**
- **Telephone Number:**

**State Case I.D. Number:** 77993-4

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**CLINICAL**

<table>
<thead>
<tr>
<th>Y=Yes</th>
<th>N=No</th>
<th>U=Unknown</th>
</tr>
</thead>
</table>

#### CONDITION

10. **Diagnosis**  
   - Date: [77975-1]  

11. **Illness Onset Date**
   - Date: [11368-8]

#### SIGNS/SYMPTOMS

12. **Rash Onset Date**
   - Date: [81268-5]

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?**
   - Number of lesions:
     - <50: [ ]
     - 50-249: [ ]
     - 250-499: [ ]
     - 500+: [ ]

15. **Character of Lesions (with <50)**
   - Macules (flat) present: [ ]
   - Papules (raised) present: [ ]
   - Vesicles (fluid) present: [ ]

16. **Character of lesions (all categories – 1 to >500)**
   - Mostly macular/papular: [ ]
   - Mostly vesicular: [ ]
   - Hemorrhagic: [INV911]
   - Itchy: [INV913]
   - Scabs: [N=No]

17. **Did the rash crust?**
   - [INV913]

18. **Did the patient have a fever?**

19. **Date of Fever Onset**
   - Date: [81264-1]

20. **Highest measured temperature:**
   - °F / °C
   - [ ]

21. **Total number of days with fever:**
   - [ ]

22. **Is patient immunocompromised due to medical condition or treatment?**
   - [ ]

#### COMPLICATIONS

23. **Did the patient visit a healthcare provider during this illness?**
   - [VAR128]

24. **Did the patient develop any complications that were diagnosed by a healthcare provider?**
   - [ ]
   - [INV920]

25. **Was the patient treated with acyclovir, famvir, or any licensed antiviral for this illness?**
   - [ ]
   - [INV923]

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**Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the needed data, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATS/DR, Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; OMB PRA (0920-0007).**

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**Varicella Surveillance**

8/30/18
26. Was the patient hospitalized for this illness? If “yes”:
   ☐ Y ☐ N ☒ U

   Admission Date [8656-1] MONTH DAY YEAR

   Discharge Date [8649-6] MONTH DAY YEAR

   Total duration of stay in hospital [78033-8] _____ 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 [PID-29] MONTH DAY YEAR

   Autopsy performed? ☐ Y ☐ N ☒ U

   Cause of death __________________________

   NOTE: Fill out varicella death worksheet.

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## LABORATORY

<table>
<thead>
<tr>
<th>Y=Yes</th>
<th>N=No</th>
<th>U=Unknown</th>
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<tbody>
<tr>
<td>☐ Y</td>
<td>☐ N</td>
<td>☐ U</td>
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</table>

28. Was laboratory testing done for varicella? ☐ Y ☐ N ☒ U

   LAB [LAB630]

   If “yes”:

29. Direct fluorescent antibody (DFA) Technique? ☐ Y ☐ N ☒ U

   Date of DFA [68963-8] MONTH DAY YEAR

   DFA Result [INV291]

   ☐ Positive ☐ Pending ☐ Negative ☐ Not Done ☐ Indeterminate ☒ Unknown

30. PCR specimen ☐ Y ☐ N ☒ U

   Date of PCR [68963-8] MONTH DAY YEAR

   Source of PCR specimen (check all that apply) [31208-2]

   ☐ Vesicular swab ☐ Saliva ☐ Scab ☐ Blood ☐ Tissue Culture ☐ Urine ☐ Buccal Swab ☐ Macular Scraping ☐ Other ______________

31. Culture performed? ☐ Y ☐ N ☒ U

   Date of Culture [68963-8] MONTH DAY YEAR

   Culture Result [INV291]

   ☐ Positive ☐ Pending ☐ Negative ☐ Not Done ☐ Indeterminate ☒ Unknown

32. Was other laboratory testing done? If “yes”:

   Specify ☐ Tzanck smear

   Other Test ☐ Electron microscopy

   Date of Other Test [68963-8] MONTH DAY YEAR

33. Serology performed? ☐ Y ☐ N ☒ U

34. IgM performed? ☐ Y ☐ N ☒ U

   Type of IgM Test ☐ Capture ELISA ☐ Indirect ELISA ☐ Other ______________

   Date IgM [68963-8] MONTH DAY YEAR

   Specimen Taken ☐ Y ☐ N ☒ U

   IgM Test Result [INV291]

   ☐ Positive ☐ Pending ☐ Negative ☐ Not Done ☐ Indeterminate ☒ Unknown

   Test Result Value ☐ LAB628

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 [68963-8] MONTH DAY YEAR

   IgG Acute Result [INV291]

   ☐ Positive ☐ Pending ☐ Negative ☐ Not Done ☐ Indeterminate ☒ Unknown

   Test Result Value ☐ LAB628

36. Were the clinical specimens sent to CDC for genotyping (molecular typing?) If “yes”:

   Date sent for genotyping [85930-6] MONTH DAY YEAR

37. Was specimen sent for strain identification? ☐ Y ☐ N ☒ U

   Strain Type ☐ Wild Type Strain ☐ Vaccine Type Strain ☒ Unknown
### VACCINE INFORMATION

<table>
<thead>
<tr>
<th>VACCINE INFORMATION</th>
<th>Y=Yes</th>
<th>N=No</th>
<th>U=Unknown</th>
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<tbody>
<tr>
<td>38. Did the patient receive varicella-containing vaccine?</td>
<td>☐ Y ☐ N ☐ U</td>
<td>☐ Y ☐ N ☐ U</td>
<td></td>
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<tr>
<td>☐ Born outside the United States</td>
<td>☐ Lab evidence of previous disease</td>
<td>☐ MD diagnosis of previous disease</td>
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<tr>
<td>☐ Medical contraindication</td>
<td>☐ Never offered vaccine</td>
<td>☐ Parent/patient forgot to vaccinate</td>
<td></td>
</tr>
<tr>
<td>☐ Parent/patient refusal</td>
<td>☐ Parent/patient report of previous disease</td>
<td>☐ Philosophical objection</td>
<td></td>
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<tr>
<td>☐ Religious exemption</td>
<td>☐ Under age for vaccination</td>
<td>☐ Other ____________________________</td>
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<tr>
<td>☐ Unknown</td>
<td>☐ Unknown</td>
<td>☐ Unknown</td>
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### VACCINATION RECORD

<table>
<thead>
<tr>
<th>Vaccination Date(s)</th>
<th>Vaccine Type</th>
<th>Manufacturer</th>
<th>Lot Number</th>
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<tbody>
<tr>
<td>30952-6</td>
<td>30956-7</td>
<td>30957-5</td>
<td>30959-1</td>
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<td>__ __ / __ __ / __ __</td>
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### EPIDEMIOLOGIC

<table>
<thead>
<tr>
<th>Date of Investigation Start Date</th>
<th>77979-3 MONTH DAY YEAR</th>
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<table>
<thead>
<tr>
<th>Has this patient ever been diagnosed with varicella before?</th>
<th>☐ Y ☐ N ☐ U</th>
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</thead>
<tbody>
<tr>
<td>☐ Yes: Age at diagnosis</td>
<td>☐ INV934</td>
</tr>
<tr>
<td>Age Type</td>
<td>☐ Years ☐ Days</td>
</tr>
<tr>
<td>☐ Months ☐ Hours</td>
<td></td>
</tr>
<tr>
<td>☐ Weeks ☐ Unknown</td>
<td></td>
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### Previous case

<table>
<thead>
<tr>
<th>Diagnosed by</th>
<th>☐ Physician/Health Care Provider</th>
<th>☐ Parent/Friend</th>
<th>☐ Other ____________________________</th>
</tr>
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</table>

### Where was the patient born (country)? | 78746-5 |

<table>
<thead>
<tr>
<th>Is this case epi-linked to another confirmed or probable case?</th>
<th>☐ Y ☐ N ☐ U</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes: Epi-linked to</td>
<td>☐ VAR155</td>
</tr>
<tr>
<td>☐ Confirmed varicella case</td>
<td>☐ Probable varicella case</td>
</tr>
</tbody>
</table>

### Transmission Setting

<table>
<thead>
<tr>
<th>Setting (Setting of Exposure)</th>
<th>☐ Athletics ☐ Hospital Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ College ☐ Clinic</td>
<td>☐ Community ☐ Hospital Ward</td>
</tr>
<tr>
<td>☐ Correctional Facility ☐ International Travel</td>
<td>☐ Daycare ☐ Military</td>
</tr>
<tr>
<td>☐ Doctor’s Office ☐ Place of Worship</td>
<td>☐ Home ☐ School</td>
</tr>
<tr>
<td>☐ Hospital ER ☐ Work</td>
<td>☐ Other _______ ☐ Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transmitted by</th>
<th>☐ 1st Trimester ☐ 2nd Trimester</th>
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</thead>
<tbody>
<tr>
<td>☐ 3rd Trimester</td>
<td>☐ 4th Trimester</td>
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</table>

### PREGNANT WOMEN

<table>
<thead>
<tr>
<th>If the case is female, is/was she pregnant during this varicella illness?</th>
<th>☐ Y ☐ N ☐ U</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes: Number of weeks gestation at Onset of illness (1-45 weeks)</td>
<td>☐ 81270-1 Weeks</td>
</tr>
<tr>
<td>☐ 81271-9</td>
<td>☐ 81275-2</td>
</tr>
</tbody>
</table>

### General Comments: | 77999-1 |