

# Varicella Surveillance Worksheet

Generic MMG

Varicella MMG

<b>NAME</b>	<b>ADDRESS (Street and No.)</b>	<b>Phone</b>	<b>Hospital Record No.</b>
(last)	(first)		

This information will not be sent to CDC

<b>REPORTING SOURCE TYPE</b> <input type="checkbox"/> physician <input type="checkbox"/> PH clinic <input type="checkbox"/> nurse <input type="checkbox"/> hospital <input type="checkbox"/> other clinic <input type="checkbox"/> other source type	<b>NAME</b> _____ <b>ADDRESS</b> _____ <b>ZIP CODE</b> 52831-5 <b>PHONE</b> (____) _____	<b>SUBJECT ADDRESS CITY</b> _____ <b>SUBJECT ADDRESS STATE</b> _____ <b>SUBJECT ADDRESS COUNTY</b> _____ <b>SUBJECT ADDRESS ZIP CODE</b> _____ <b>LOCAL SUBJECT ID</b> _____
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## CASE INFORMATION

<b>Date of Birth</b> _____ PID-7	<b>Sex</b> <input type="checkbox"/> M=male <input type="checkbox"/> F=female <input type="checkbox"/> U=unknown	<b>Ethnic Group</b> H=Hispanic or Latino N=not Hispanic/Latino PID-22 O=other _____ U=unknown <input type="checkbox"/>	
<b>Race</b> <input type="checkbox"/> American/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not asked <input type="checkbox"/> Refused to answer <input type="checkbox"/> Other 32624-9 <input type="checkbox"/> Unknown	<b>Birth Country</b> 78746-5	<b>Other Birth Place</b> 21842-0	<b>Country of Usual Residence</b> 77983-5
<b>Age at Case Investigation</b> 77998-3	<b>Age Unit*</b> _____ OBX-6 for 77998-3	<b>Reporting County</b> 77967-8	<b>Reporting State</b> 77966-0
<b>Date Reported</b> _____ 77995-9	<b>Date First Reported to PHD</b> _____ 77970-2	<b>National Reporting Jurisdiction</b> 77968-6	
<b>Earliest Date Reported to County</b> _____ 77972-8	<b>Earliest Date Reported to State</b> _____ 77973-6		
<b>Case Class Status</b> <input type="checkbox"/> Suspected <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> Unknown <input type="checkbox"/> Not a case 77990-0	<b>Case Investigation Start Date</b> _____ 77979-3		
<b>Case Investigation Status Code</b> INV109 <input type="checkbox"/> approved <input type="checkbox"/> closed <input type="checkbox"/> deleted <input type="checkbox"/> in progress <input type="checkbox"/> notified <input type="checkbox"/> other _____ <input type="checkbox"/> rejected <input type="checkbox"/> reviewed <input type="checkbox"/> suspended <input type="checkbox"/> unknown			

## CLINICAL INFORMATION

<b>Hospitalized?</b> Y=yes <input checked="" type="checkbox"/> N=no <input type="checkbox"/> U=unknown <input type="checkbox"/>	<b>Hospital Admission Date</b> _____ 8656-1	<b>Hospital Discharge Date</b> _____ 8649-6	
<b>Hospital Stay Duration</b> 0-998 _____ 78033-8 999=unknown (days)	<b>Illness Onset Date</b> _____ 11368-8	<b>Illness End Date</b> _____ 77976-9	
<b>Illness Duration</b> _____ 77977-7	<b>Illness Duration Units*</b> _____ OBX-6 for 77977-7	<b>Date of Diagnosis</b> _____ 77975-1	<b>Pregnancy Status</b> Y=yes N=no U=unknown <input type="checkbox"/> 77996-7
<b>REASON FOR HOSPITALIZATION</b> 86947-9	<input type="checkbox"/> Varicella related complications <input type="checkbox"/> Administration of IV treatment <input type="checkbox"/> Isolation <input type="checkbox"/> Non-varicella hospitalization <input type="checkbox"/> Observation <input type="checkbox"/> Other _____ <input type="checkbox"/> Severe varicella presentation <input type="checkbox"/> Unknown		
<b>Rash Onset Date</b> _____ 81268-5	<b>Rash Duration</b> _____ 81269-3 (days)	<b>Was the rash generalized?</b> Y=yes N=no U=unknown <input type="checkbox"/> 725119006	
<b>Body Regions of Rash (if rash NOT generalized)</b> 364402001	<input type="checkbox"/> Arm, hand, torso, back <input type="checkbox"/> Head/face with eye involvement <input type="checkbox"/> Head/face without eye involvement	<input type="checkbox"/> Leg <input type="checkbox"/> Neck/shoulder <input type="checkbox"/> Pelvis/groin/buttocks/hip	<input type="checkbox"/> Upper mid-abdomen/flank <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown
<b>Total Number of Lesions</b> 300579006	<input type="checkbox"/> <50 <input type="checkbox"/> 50-249 <input type="checkbox"/> 50-500 <input type="checkbox"/> 250-499 <input type="checkbox"/> >500 <input type="checkbox"/> Unknown	<b>If &lt;50 lesions, any?</b> 246206008 <input type="checkbox"/> <input type="checkbox"/>	
<b>Character of Lesion</b> 364637009	<input type="checkbox"/> papular <input type="checkbox"/> Vesicular <input type="checkbox"/> other _____ <input type="checkbox"/> unknown	<b>Were the lesions hemorrhagic?</b> INV911 Y=yes N=no U=unknown <input type="checkbox"/>	
<b>Were the lesions itchy?</b> 418290006 Y=yes N=no U=unknown <input type="checkbox"/>	<b>Did the lesions appear in crops/waves?</b> INV912 Y=yes N=no U=unknown <input type="checkbox"/>		
<b>Did the lesions crust/scab over?</b> INV913 Y=yes N=no U=unknown <input type="checkbox"/>	<b>Is patient immunocompromised?</b> Y=yes 370388006 U=unknown <input type="checkbox"/>		
<b>If patient immunocompromised, then immunocompromised-associated condition or treatment</b> INV933 _____			
<b>Did patient visit a healthcare provider during this illness?</b> VAR128 Y=yes N=no U=unknown <input type="checkbox"/>	<b>Fever?</b> 386661006 N=no U=unknown <input type="checkbox"/>		
<b>Fever Onset Date</b> _____ 81266-9	<b>Fever Duration</b> _____ 81264-4 (days)	<b>Highest Temperature</b> _____ 81265-1	<b>Temperature Units</b> _____ OBX-6 for 81265-1 <input type="checkbox"/> °C <input type="checkbox"/> °F

\*UNITS a=year h=hour mo=month wk=week d=day min=minute s=second UNK=unknown

## COMPLICATIONS

<b>TYPE OF COMPLICATIONS</b> <span style="border: 1px solid black; padding: 2px;">67187-5</span>	<span style="border: 1px solid black; padding: 2px;">INV920</span> Y N U	<span style="border: 1px solid black; padding: 2px;">INV920</span> Y N U	<span style="border: 1px solid black; padding: 2px;">INV920</span> Y N U D
	cerebellitis/ataxia	skin/soft tissue infection	Pneumonia
	dehydration	other _____	Chest X-ray for pneumonia <span style="border: 1px solid black; padding: 2px;">INV923</span>
	hemorrhagic condition	varicella encephalitis	Y=yes N=no U=unknown D=not done

**Subject death from this illness or complications of this illness?** 77978-5 Y=yes N=no U=unknown  **Deceased Date** PID-29 month day year

## TREATMENT

**Antiviral medication?** VAR139 Y=yes N=no U=unknown  **Treatment Start Date** 86948-7 month day year **Treatment Duration** 67453-1 (days)

**Medication received:** 29303-5  acyclovir  famciclovir  valacyclovir  other \_\_\_\_\_  unknown

## LABORATORY TESTING

**VPD Lab Message Reference Laboratory** LAB143 **VPD Lab Message Patient Identifier** LAB598 **VPD Lab Message Specimen Identifier** LAB125

**Was laboratory testing done to confirm the diagnosis?** LAB630 Y=yes N=no U=unknown

**Was a laboratory-confirmed?** INV164 Y=yes N=no U=unknown  **Was a specimen sent to CDC for testing?** 82314-6 Y=yes N=no U=unknown

Test Type	Test Result	Date Specimen Collected	Test Result Quantitative	Result Units	Specimen Source	Date Specimen Sent to CDC	Date Specimen Analyzed	Performing Laboratory Type
<span style="border: 1px solid black; padding: 2px;">INV290</span>	<span style="border: 1px solid black; padding: 2px;">INV291</span>	<span style="border: 1px solid black; padding: 2px;">68963-8</span> [mm dd yyyy]	<span style="border: 1px solid black; padding: 2px;">LAB628</span>	<span style="border: 1px solid black; padding: 2px;">LAB115</span>	<span style="border: 1px solid black; padding: 2px;">31208-2</span>	<span style="border: 1px solid black; padding: 2px;">85930-6</span> [mm dd yyyy]	<span style="border: 1px solid black; padding: 2px;">OBX-19</span> [mm dd yyyy]	<span style="border: 1px solid black; padding: 2px;">82771-7</span>
IgM		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">8048-1</span>								
IgG avidity		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">LAB632</span>								
IgG (acute)		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">LAB637</span>								
IgG (conv)		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">LAB638</span>								
IgG EIA		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">15410-4</span>								
unspecified serology		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">LAB707</span>								
Culture		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">10860-5</span>								
DFA		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">5882-6</span>								
PCR		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">11463-5</span>								
Genotype		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">LAB631</span>								
Other		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">LAB608</span>								
Strain ID		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">82746-9</span>								
Unknown		-----				-----	-----	
<span style="border: 1px solid black; padding: 2px;">LAB609</span>								

### Specimen Source Codes

- |                    |                   |                       |
|--------------------|-------------------|-----------------------|
| 1=blood            | 8=other (specify) | 15=swab (skin lesion) |
| 2=bronchoalveolar  | 9=unknown         | 16=throat swab        |
| 3=CSF              | 10=NP washing     | 17=tissue             |
| 4=crust            | 11=saliva         | 18=urine              |
| 5=lesion           | 12=scab           | 19=vesicle fluid      |
| 6=macular scraping | 13=serum          | 20=vesicular swab     |
| 7=NP swab          | 14=skin lesion    |                       |

### Test Results Codes

P=positive N=negative X=not done  
 I=Indeterminate E=pending O=other (specify)  
 IN=inadequate NS=no significant rise in IgG  
 PS=significant rise in IgG U=unknown  
 V=vaccine type strain W=wild type strain

### Performing Laboratory Type

- |                     |                      |
|---------------------|----------------------|
| 1=CDC lab           | 2=commercial lab     |
| 3=hospital lab      | 4=other clinical lab |
| 5=public health lab | 6=VPD testing lab    |
| 8=other             | 9=unknown            |

## VACCINATION HISTORY

**VACCINATED (has the case-patient ever received varicella-containing vaccine)?**  VAC126 Y=yes N=no U=unknown

**Number of vaccine doses received on or after first birthday?**  VAC129 0-6 99=unknown

**Number of vaccine doses received prior to illness onset?**  82745-1 0-6 99=unknown  (doses)

**Date of last dose prior to illness onset?**  VAC142 \_\_\_\_-\_\_\_\_-\_\_\_\_ [mm/dd/yyyy]

**Was case-patient vaccinated as recommended by the ACIP?**

VAC148 Y=yes N=no U=unknown

Vaccine Type	Vaccination Date	Vaccine Manuf	Vaccine Lot Number	Vaccine Expiry Date	National Drug Code	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number
<input checked="" type="checkbox"/> 30956-7	<input checked="" type="checkbox"/> 30952-6 [mm dd yyyy]	<input checked="" type="checkbox"/> 30957-5	<input checked="" type="checkbox"/> 30959-1	<input checked="" type="checkbox"/> VAC109 [mm dd yyyy]	<input checked="" type="checkbox"/> VAC153	<input checked="" type="checkbox"/> VAC102	<input checked="" type="checkbox"/> VAC147	<input checked="" type="checkbox"/> 30973-2

<p style="text-align: center;"><b>VACCINE TYPE CODES</b></p> <p>M=measles/mumps/rubella/varicella [MMRV]  V = varicella vaccine  O = other (specify) _____  U = unknown</p>	<p style="text-align: center;"><b>VACCINE MANUFACTURER CODES</b></p> <p>M = Merck  O = other (specify) _____  U = unknown</p>	<p style="text-align: center;"><b>VACCINE EVENT INFORMATION SOURCE CODES</b></p> <p>00= new immunization record  01= historical information, source unidentified  02= historical information, other provider  05= historical information, other registry  06= historical information, birth certificate  07= historical information, school record  08= historical information, public agency  09= historical information, patient or parent recall  10= historical information, patient or parent written record</p>
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**REASON NOT VACCINATED PER ACIP**  VAC149

1 = religious exemption	6 = too young	11 = vaccine record incomplete/unavailable
2 = medical contraindication	7 = parent/patient refusal	12 = parent/patient report of previous disease
3 = philosophical objection	8 = other _____	13 = parent/patient unaware of recommendation
4 = lab evidence of previous disease	9 = unknown	14 = missed opportunity
5 = MD diagnosis of previous disease	10 = parent/patient forgot to vaccinate	15 = foreign visitor <input type="checkbox"/>
		16 = immigrant <input type="checkbox"/>

### EPIDEMIOLOGIC

**Has patient been diagnosed  VAR150 varicella before?** Y=yes N=no U=unknown  **Age at patient's diagnosis?**  INV934 **Age Units<sup>+</sup>**  OBX-6

**Previous case was diagnosed by**  VAR152  Parent  Physician/Healthcare provider  Other \_\_\_\_\_  Unknown

**If case pregnant at  81270-1 onset, weeks gestation?**  **If case pregnant at illness onset, trimester of gestation?**  81271-9

**Is case-patient  223366009 healthcare worker?** Y=yes N=no U=unknown  **Epi-linked  VAR154 confirmed or probable case?** Y=yes N=no U=unknown

**If epi-linked, type of case:**  VAR155  confirmed varicella  probable varicella  herpes zoster  unknown

<b>Transmission Setting</b> <input checked="" type="checkbox"/> 81267-7	1=day care 2=school 3=doctor's office 4=hospital ward 5=hospital ER 6=hospital outpatient clinic 7=home 8=other _____ 9=unknown 10=college 11=military 12=correctional facility 13=place of worship 14=international travel 15=community 16=work 17=athletics <input type="checkbox"/>	<b>Transmission Mode</b> <input checked="" type="checkbox"/> 77989-2
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\*UNITS  OBX-6 for INV934 a=year mo=month w=week d=day UNK=unknown

### EXPOSURE

**Outbreak related?**  77980-1 N=no U=unknown  **Outbreak Name**  77981-9 **COUNTRY of Exposure**  77984-3

**STATE/PROVINCE of Exposure**  77985-0 **COUNTY of Exposure**  77987-6 **CITY of Exposure**  77986-8

## CASE NOTIFICATION

<b>Condition Code</b> <span style="border: 1px solid red; padding: 2px;">OBR-31</span> <b>10030</b>		<b>Immediate Notifiable Condition</b> <span style="border: 1px solid red; padding: 2px;">77965-2</span> Y=yes N=no U=unknown <input type="checkbox"/>		<b>Legacy Case ID</b> <span style="border: 1px solid red; padding: 2px;">77997-5</span>	
<b>State Case ID</b> <span style="border: 1px solid red; padding: 2px;">77993-4</span>		<b>Local Record ID</b> <span style="border: 1px solid red; padding: 2px;">OBR-3</span>		<b>Jurisdiction Code</b> <span style="border: 1px solid red; padding: 2px;">77969-4</span>	
<b>Date First Verbal Notification to CDC</b> <span style="border: 1px solid red; padding: 2px;">77994-2</span>		<b>Date First Electronically Submitted</b> <span style="border: 1px solid red; padding: 2px;">OBR-7</span>		<b>Binational Reporting Criteria</b>	
<b>Date of Electronic Case Notification to CDC</b> <span style="border: 1px solid red; padding: 2px;">OBR-22</span>		<b>MMWR Week</b> <span style="border: 1px solid red; padding: 2px;">77991-8</span>		<b>MMWR Year</b> <span style="border: 1px solid red; padding: 2px;">77992-6</span>	
<b>Notification Result Status</b> <span style="border: 1px solid red; padding: 2px;">OBR-25</span> F = Final C = Record is a correction X = Results cannot be obtained <input type="checkbox"/>					
<b>Person Reporting to CDC NAME</b> <span style="border: 1px solid red; padding: 2px;">74549-7</span>			<b>Person Reporting to CDC Email</b> <span style="border: 1px solid red; padding: 2px;">74547-1</span> @		
(first) _____ (last) _____			<b>Person Reporting to CDC Phone Number</b> <span style="border: 1px solid red; padding: 2px;">74548-9</span> (____) _____		
<b>Current Occupation</b> <span style="border: 1px solid red; padding: 2px;">85658-3</span>			<b>Current Occupation Standardized</b> <span style="border: 1px solid red; padding: 2px;">85659-1</span>		
<b>Current Industry</b> <span style="border: 1px solid red; padding: 2px;">85078-4</span>			<b>Current Industry Standardized</b> <span style="border: 1px solid red; padding: 2px;">85657-5</span>		
<b>Comments</b> <span style="border: 1px solid red; padding: 2px;">77999-1</span>					

### CLINICAL CASE DEFINITION <sup>†</sup>

#### PROBABLE

An acute illness with

- Diffuse (generalized) maculo-papulovesicular rash, **AND**
- Lack of laboratory confirmation, **AND**
- Lack of epidemiologic linkage to another probable or confirmed case

#### CONFIRMED

An acute illness with diffuse (generalized) maculo-papulovesicular rash, **AND**

- Epidemiologic linkage to another probable or confirmed case, **OR**
- Laboratory confirmation by any of the following:
  - Isolation of varicella virus from a clinical specimen, **OR**
  - Varicella antigen detected by direct fluorescent antibody test, **OR**
  - Varicella-specific nucleic acid detected by polymerase chain reaction (PCR), **OR**
  - Significant rise in serum anti-varicella immunoglobulin G (IgG) antibody level by any standard serologic assay.

<sup>†</sup>CSTE Position Statement 09-ID-68 at <https://www.cdc.gov/nndss/conditions/varicella/case-definition/2010>