Varicella Case Investigation Questionnaire

Patient name (Last, First):	**Patient Date of Birth:**

Epidemiologic Information

Did the patient have contact with another person with chickenpox or shingles rash illness 28 days prior to symptom onset?
Y ☐ N ☐ Unknown ☐
If yes, specify type contact name and relationship to case-patient (if available): _____

Did the patient attend day care* or school while infectious (e.g., 2 days before rash onset until all the lesions crusted over?
Y ☐ N ☐ Unknown ☐
If yes, specify name of facility, location, and phone number (if available): _____
*Day care is defined as a supervised group of 2 or more unrelated children for at least 4 hours per week

Does the patient reside in a residential institution? Y ☐ N ☐ Unknown ☐
If yes, specify name of facility, location, and phone number (if available): _____

Does the patient have contact with persons who may be at high risk for complications from varicella disease because of their age or an underlying condition (e.g., immunocompromised persons, cancer patients, pregnant women, neonates whose mothers are not immune) while infectious?
Y ☐ N ☐ Unknown ☐
If yes, provide further specification: _____

Household and close contacts (provide information on any additional contacts on a separate sheet)

Name	DOB	Relationship to case	Household Member? *(Y, N)*	Evidence of immunity to varicella or Vaccination History *(dates)*	High-risk due to age or health condition? *(Y, N)*	VZIG Recommended? *(Y, N, U and date if Y)*

Notes:

Completed by: _____ Phone: _____ Date: _____

Varicella Surveillance Worksheet

NAME _____ (last) _____ (first) **ADDRESS (Street and No.)** _____ **Phone** _____ **Hospital Record No.** _____

This information will not be sent to CDC

REPORTING SOURCE TYPE
☐ physician ☐ PH clinic
☐ nurse ☐ laboratory
☐ hospital ☐ other clinic
☐ other source type _____

NAME _____
ADDRESS _____
ZIP CODE _____
PHONE (__ __ __) __ __ __ __ __ __ __

SUBJECT ADDRESS CITY _____
SUBJECT ADDRESS STATE _____
SUBJECT ADDRESS COUNTY _____
SUBJECT ADDRESS ZIP CODE __ __ __ __ __
LOCAL SUBJECT ID _____

CASE INFORMATION

Date of Birth __ __ __ __ __ __ __ __ (month day year)
Sex M=male F=female U=unknown ☐
Ethnic Group H=Hispanic/Latino N=not Hispanic/Latino O=other _____ U=unknown

Race ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐ White ☐Not asked Refused to answer ☐Other_____ ☐Unknown_____

Birth Place_____ **Other Birth Place** _____ **Country of Usual Residence** _____

Age at Case Investigation ____ **Age Unit*** _____ **Reporting County** _____ **Reporting State** _____

Date Reported __ __ __ __ __ __ __ __ (month day year)
Date First Reported to PHD __ __ __ __ __ __ __ __ (month day year)
National Reporting Jurisdiction _____

Earliest Date Reported to County __ __ __ __ __ __ __ __ (month day year)
Earliest Date Reported to State __ __ __ __ __ __ __ __ (month day year)

Case Class Status ☐ Suspected ☐ Probable ☐ Confirmed ☐ Unknown ☐ Not a case
Case Investigation Start Date __ __ __ __ __ __ __ __ (month day year)

Case Investigation Status Code ☐approved ☐closed ☐deleted ☐in progress ☐notified ☐ other_____ ☐ rejected ☐ reviewed ☐suspended ☐unknown

CLINCAL INFORMATION

Hospitalized? Y=yes N=no U=unknown ☐
Hospital Admission Date __ __ __ __ __ __ __ __ (month day year)
Hospital Discharge Date __ __ __ __ __ __ __ __ (month day year)

Hospital Stay Duration 0 – 998 ☐☐☐ (days) 999=unknown
Illness Onset Date __ __ __ __ __ __ __ __ (month day year)
Illness End Date __ __ __ __ __ __ __ __ (month day year)

Illness Duration ___
Illness Duration Units* ___
Date of Diagnosis __ __ __ __ __ __ __ __ (month day year)
Pregnancy Status Y=yes N=no U=unknown ☐

REASON FOR HOSPITALIZATION
☐ Varicella related complications ☐ Administration of IV treatment ☐ Isolation ☐ Non-varicella hospitalization
☐ Observation ☐ Other _____ ☐ Severe varicella presentation ☐ Unknown

Rash Onset Date __ __ __ __ __ __ __ __ (month day year)
Rash Duration ____ (days)
Was the rash generalized? Y=yes N=no U=unknown ☐

BODY REGIONS OF RASH (if rash not generalized)

☐ Arm, hand, torso, back	☐ Leg	☐ Upper mid-abdomen/flank
☐ Head/face with eye involvement	☐ Neck/shoulder	☐ Other (specify) _____
☐ Head/face without eye involvement	☐ Pelvis/groin/buttocks/hip	☐ Unknown

Total Number of Lesions ☐ <50 ☐ 50-249 ☐ 50-500 ☐ 250-499 ☐ >500 ☐ Unknown
If <50 lesions, how many? ☐☐

Character of Lesions ☐ Maculopapular ☐ Vesicular ☐ other _____ ☐unknown
Were the lesions hemorrhagic? Y=yes N=no U=unknown ☐

Were the lesions itchy? Y=yes N=no U=unknown ☐
Did the lesions appear in crops/waves? Y=yes N=no U=unknown ☐

Did the lesions crust/scab over? Y=yes N=no U=unknown ☐
Is patient immunocompromised? Y=yes N=no U=unknown ☐

If patient immunocompromised, then immunocompromised-associated condition or treatment: _____

Did patient visit a healthcare provider during this illness? Y=yes N=no U=unknown ☐
Fever ? Y=yes N=no U=unknown ☐

Fever Onset Date __ __ __ __ __ __ __ __ (month day year)
Fever Duration _____ (days)
Highest Temperature _____ . ___
Temperature Units ☐°Cel ☐°F

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

COMPLICATIONS

TYPE OF COMPLICATIONS

	Y	N	U
cerebellitis/ataxia			
dehydration			
hemorrhagic condition			

	Y	N	U
skin/soft tissue infection			
other _____			
varicella encephalitis			

	Y	N	U	D
pneumonia				
Chest X-ray for pneumonia				

Y=yes **N**=no **U**=unknown **D**=not done

Subject's death from this illness or complications of this illness? Y=yes N=no U=unknown ☐

Deceased Date __ __ __ __ __ __ __ __
month day year

TREATMENT

Antiviral medication? Y=yes N=no U=unknown ☐

Treatment Start Date __ __ __ __ __ __ __ __
month day year

Treatment Duration _____ (days)

Medication received: ☐ acyclovir ☐ famciclovir ☐ valacyclovir ☐ other _____ ☐ unknown

LABORATORY TESTING

VPD Lab Message Reference Laboratory _____

VPD Lab Message Patient Identifier _____

VPD Lab Message Specimen Identifier _____

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

Was case laboratory-confirmed? Y=yes N=no U=unknown ☐

Was a specimen sent to CDC for testing? Y=yes N=no U=unknown ☐

Test Type	Test Result	Date Specimen Collected [mm dd yyyy]	Test Result Quantitative	Result Units	Specimen Source	Date Specimen Sent to CDC [mm dd yyyy]	Date Specimen Analyzed [mm dd yyyy]	Performing Laboratory Type
IgM		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
IgG avidity		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
IgG (acute)		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
IgG (conv)		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
IgG EIA		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
unspecified serology		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
Culture		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
DFA		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
PCR		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
Genotype		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
Other		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
Strain ID		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	
Unknown		__ __ __ __ __ __ __ __				__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	

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

Specimen Source Codes

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

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)? Y=yes N=no U=unknown ☐

Number of vaccine doses received on or after first birthday? 0 – 6 99=unknown ☐☐ (doses)

Number of vaccine doses received prior to illness onset? 0–6 99=unknown ☐☐ (doses)

Date of last vaccine dose prior to illness onset? __ __ __ __ __ __ __ __ (mm/dd/yyyy)

Was case-patient vaccinated as recommended by the ACIP? Y=yes N=no U=unknown ☐

Vaccine Type	Vaccination Date (month day year)	Vaccine Manuf	Vaccine Lot Number	Vaccine Expiry Date (month day year)	National Drug Code	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___

VACCINE TYPE CODES

M=measles/mumps/rubella/varicella [MMRV]
V = varicella vaccine
O = other (specify) ________________
U= unknown

VACCINE MANUFACTURER CODES

M = Merck
O = other (specify) ______________
U = unknown

VACCINE EVENT INFORMATION SOURCE CODES

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
OTH= other _________
UNK= unknown

REASON NOT VACCINATED PER ACIP

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

☐☐

EPIDEMIOLOGIC

Has patient been diagnosed with varicella before? Y=yes N=no U=unknown ☐ **Age at previous diagnosis?**___ **Age Units†** ____

Previous case was diagnosed by: ☐ Parent ☐ Physician/Healthcare provider ☐ Other_________________ ☐ Unknown

If case pregnant at illness onset, weeks gestation? ☐☐ **If case pregnant at illness onset, what was trimester of gestation?** ☐

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

If epi-linked, type of case: ☐ confirmed varicella ☐ probable varicella ☐ herpes zoster ☐ unknown **Transmission Mode** ___________

Transmission Setting 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 ☐☐

†UNITS a=year mo=month w=week d=day UNK=unknown

EXPOSURE

Outbreak Related? Y=yes N=no U=unknown ☐ **Outbreak Name** ______________ **COUNTRY of Exposure** ________________

STATE/PROVINCE of Exposure ________ **COUNTY of Exposure** ________________ **CITY of Exposure** ____________________

CASE NOTIFICATION

Condition Code 10030	**Immediate National Notifiable Condition** Y=yes N=no U=unknown ☐		**Legacy Case ID** _____
State Case ID_____	**Local Record ID** _____	**Jurisdiction Code** _____	**Binational Reporting Criteria** _ _ _ _ _ _ _ _
Date First Verbal Notification to CDC _ _ _ _ _ _ _ _ (month day year)		**Date First Electonically Submitted** _ _ _ _ _ _ _ _ (month day year)	
Date of Electronic Case Notification to CDC _ _ _ _ _ _ _ _ (month day year)		**MMWR Week** ____	**MMWR Year** _____
Notification Result Status F = Final C = Record is a correction X = Results cannot be obtained ☐			
Person Reporting to CDC NAME _____ (first) _____ (last)		**Person Reporting to CDC Email** _____ @ _____ **Person Reporting to CDC Phone Number** (_ _ _) _ _ _ _ _ _ _ _	
Current Occupation _____		**Current Occupation Standardized** _____	
Current Industry _____		**Current Industry Standardized** _____	

CLINICAL CASE DEFINITION ₮

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:
  - o Isolation of varicella virus from a clinical specimen, **OR**
  - o Varicella antigen detected by direct fluorescent antibody test, **OR**
  - o Varicella-specific nucleic acid detected by polymerase chain reaction (PCR), **OR**
  - o Significant rise in serum anti-varicella immunoglobulin G (IgG) antibody level by any standard serologic assay.

₮CSTE Position Statement 09-ID-68 at https://wwwn.cdc.gov/nndss/conditions/varicella/case-definition/2010