VARICELLA SURVEILLANCE WORKSHEET For Local Use Only State Case I.D. Number_ Name LAST / FIRST / MIDDLE Reporting Physician/ Current NUMBER / STREET / APT. NUMBER Address Nurse/Hospital/ Clinic/Lab / COUNTY / STATE ZIP CODE ADDRESS Telephone: Home. Work Telephone Number AREA CODE + 7 DIGITS AREA CODE + 7 DIGITS AREA CODE + 7 DIGITS Detach here — Transmit only lower portion if sent to CDC Form Approved VARICELLA SURVEILLANCE WORKSHEET OMB No. 0920-0007 Exp. Date 7/31/2007 Reported by: State County REPORTING SOURCE 1. Date of Birth Date of 2. Current Age Report ☐ Days Hours 3. Age Type ∃Years **Earliest Date** Reported to Months ☐ Weeks Unknown County 4. Current Sex Male □ Female Unknown **Earliest Date** 5. Ethnicity Not Hispanic Unknown Reported to State 6. Race American Indian or Alaska Native Asian Black or African-American Native Hawaiian or Other Pacific Islander White Unknown **CLINICAL** Y=Yes N=No U=Unknown CONDITION 18. Did the patient have a fever? Diagnosis Date of Date Fever Onset 11. Illness °F / °C 20. Highest measured temperature: **Onset Date** 21. Total number of days with fever: Days SIGNS/SYMPTOMS 22. Is patient immunocompromised due Y N **Rash Onset** to medical condition or treatment? Date (If yes, specify) Generalized Focal Unknown Rash 13. Location COMPLICATIONS If "Focal," specify dermatome: 23. Did the patient visit a healthcare \square Y \square N \square U If "Generalized," first noted: (check all that apply) provider during this illness? Face/Head Leas ☐ Trunk 24. Did the patient develop any \square Y \square N \square U ☐ Inside Mouth Arms complications that were diagnosed Other (specify) by a healthcare provider? If "yes": Skin/Soft Tissue Infection **Y** □ N 14. How many lesions were there in total? Cerebellitis/Ataxia N <50</p> 50-249 250-499 ٦Y lυ ٦Y N Encephalitis] U 15. Character of Lesions (with <50) Number of lesions:_ Dehydration _] Y \square N ٦u Macules (flat) present: Y N U Number: __ Hemorrhagic Condition] Y \square N □Ū Papules (raised) present: Y N U Number: ___ Pneumonia **Y** \square N Vesicles (fluid) present: Y N U Number: ___ How diagnosed: ☐ X-ray \square U 16. Character of Lesions (all categories-1 to >500) Other Complications \square Y \square N \square U Mostly macular/papular γ N (Specify) \rfloor N Mostly vesicular] Y 25. Was the patient treated with \square Y \square N \square U ٦Y \square N Hemorrhagic Īυ acyclovir, famvir, or any licensed

Days

Days

antiviral for this illness? If "yes,"

Name of medication:

Start Date

Stop Date

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If "yes," how many days until all the

If "no," how many days did the rash last?

Itchy

Scabs

Crops/waves

17. Did the rash crust?

lesions crusted over?

26.	Was the patient hospitalized	27.	Did the patient die from varicella						
LABORATORY Y=Yes N=No U=Unknown									
28.	Was laboratory testing done Y N U for varicella? If "yes":	34.	lgM performed?						
29.	Direct fluorescent antibody (DFA) ☐ Y ☐ N ☐ U technique?		Type of Capture ELISA Unknown IgMTest Indirect ELISA Other						
	Date of DFA DAY YEAR		Date IgM Specimen Taken MONTH DAY YEAR						
	DFA Result ☐ Positive ☐ Pending ☐ Negative ☐ Not Done ☐ Indeterminate ☐ Unknown		IgM Test Result □ Positive □ Pending Negative □ Not Done □ Indeterminate □ Unknown						
30.	PCR specimen?		Test Result Value						
	Date of PCR Specimen MONTH DAY YEAR	35.	lgG performed?						
	Source of PCR specimen: (check all that apply) Vesicular Swab Saliva Scab Blood Tissue Culture Urine Buccal Swab Macular Scraping Other		Type of IgG Test: Whole Cell ELISA (specify manufacturer): gp ELISA (specify manufacturer): FAMA Latex Bead Agglutination						
	PCR Result Positive Not Done Negative Pending Indeterminate Unknown Other		Date of IgG-Acute MONTH DAY YEAR						
31.	Culture performed?		IgG-Acute ☐ Positive ☐ Pending Result ☐ Negative ☐ Not Done						
	Date of Culture Specimen MONTH DAY YEAR]	☐ Indeterminate ☐ Unknown Test Result Value						
	Culture Positive Pending Result Negative Not Done Indeterminate Unknown		Date of IgG-Convalescent MONTH DAY YEAR IgG-Conv. Positive Pending						
32.	Was other laboratory testing		Result Negative Not Done Indeterminate Unknown						
	Specify		Test Result Value						
	Date of Other Test MONTH DAY YEAR	36.	Were the clinical specimens sent ☐ Y ☐ N ☐ U to CDC for genotyping (molecular typing)? If "yes":						
	Other Lab	37.	Date sent for genotyping MONTH DAY YEAR Was specimen sent for strain Y N U (wild- or vaccine-type) identification? Strain Type Wild Type Strain						
33	Serology performed?		☐ Vaccine Type Strain☐ Unknown						
00.		1							

7	VACCINE INFORMA	TION Y=	Yes N=No U=Un	known				
38.	Did the patient receive Y N U varicella-containing vaccine?			Number of doses rec <u>after</u> first birthday:	eived <u>on</u> or	[Doses	
If "no," reason: Born outside the United States Lab evidence of previous disease MD diagnosis of previous disease Medical contraindication Never offered vaccine Parent/patient forgot to vaccinate Parent/patient refusal Parent/patient report of previous disease Philosophical objection Religious exemption Under age for vaccination Other Unknown				40. If patient is >=13 years old and received one dose on or after 13th birthday but never received second dose, what is the reason? Born outside the United States Lab evidence of previous disease MD diagnosis of previous disease Medical contraindication Never offered vaccine Parent/patient forgot to vaccinate Parent/patient refusal Parent/patient report of previous disease Philosophical objection Religious exemption Other Unknown				
7	VACCINATION REC	OPD						
						Manuface		
	accination Date(s)	Vaccine Type	Ma	anufacturer	Lot	Number		
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	_'							
41.	Case Investigation Start Date MONTH Has this patient eved diagnosed with varief "yes":	Pr been Y N U		Is this case a healthout Is this case part of an of 5 or more cases? If "yes": Outbreak Name:		YN YN	U U	
	Age at		49.	Case Status: ☐ Conf	ïrmed			
	Diagnosis Age Type Years Days Suspect Not a Case Unknown Unknown							
43.	. •	Physician/Health Care Provider	50.	MMWR Week:				
		arent/Friend ther		MMWR Year:				
44.	Where was the patie	ent born (country)?	PR	EGNANT WOMEN				
45.	confirmed or proba If "yes," Conepi-linked to: Pro	ted to another Y N Uble case? Infirmed Varicella Case obable Varicella Case rpes Zoster Case		If the case is female, she pregnant during varicella illness? If "yes":	this	Y	U	
46.	Col Col	llege Clinic mmunity Hospital Ward rrectional Facility International Tra ycare Military ctor's Office Place of Worsh me School spital ER Work	avel 53.	onset of illness (1-45 Trimester	weeks): rimester Trimester rimester		Veeks	
	Oth	ner 🔲 Unknown	1					