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 ☐
Ethnic Group H=Hispanic/Latino N=not Hispanic/Latino O=other _____ U=unknown ☐

Race

☐	American Indian/Alaskan Native	☐	Asian	☐	Native Hawaiian/Pacific Islander	☐	Not asked	☐	Unknown
☐	Black/African American	☐	White	☐	Other _____	☐	Refused to answer		

Birth Country _____
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

☐	Severe varicella presentation
☐	Varicella complications
☐	Observation
☐	IV treatment
☐	Non-varicella hospitalization
☐	Isolation
☐	Other _____
☐	Unknown

Is a rash description available? Y=yes N=no U=unknown ☐
Was the rash generalized? Y=yes N=no U=unknown ☐
Rash Onset Date __ __ __ __ __ __ __ __ (month/day/year)
Rash Duration _____ (days)

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? ☐☐
Were lesions hemorrhagic? Y=yes N=no U=unknown ☐
Character (majority of) lesions ☐ Maculopapular ☐ Vesicular ☐ Other _____ ☐ 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 ☐
Were there any vesicles present? Y=yes N=no U=unknown ☐
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			
pneumonia			

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

Y=yes **N**=no **U**=unknown

	P	N	U	D
chest X-ray for pneumonia				

P=positive **N**=negative **U**=unknown
D=not done

Is patient immunocompromised? **Y**=yes **N**=no **U**=unknown ☐ If so, associated condition or treatment: _____

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

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

VPD Lab Message Reference Laboratory _____

VPD Lab Message Patient Identifier _____

VPD Lab Message Specimen Identifier _____

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
PCR	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
Genotype (WT or Vaccine)	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
DFA	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
Culture	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
IgM	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
IgG acute	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
IgG conv	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
IgG single	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
Serology unspecified	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
Other (specify)	_____	__ __ __ __ __ __ __ __	_____	_____	_____	__ __ __ __ __ __ __ __	__ __ __ __ __ __ __ __	_____
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
WT=wild type strain

Specimen Source Codes

1 bacterial isolate
2 blood
3 body fluid
4 BAL
5 buccal smear
6 buccal swab
7 capillary blood
8 cataract
9 CSF
10 crust
11 DNA
12 dried blood spot
13 lesion
14 macular scraping
15 microbial isolate
16 NP aspirate
17 NP swab
18 NP washing
19 nucleic acid
20 oral fluid
21 oral swab
22 plasma
23 respiratory
24 RNA
25 saliva
26 scab
27 serum
28 skin lesion
29 specimen
30 lung (bronc wash)
31 lavage specimen
32 stool
33 swab
34 skin lesion swab
35 nasal sinus swab
36 vesicular swab
37 throat swab
38 tissue specimen
39 internal nose
40 urine
41 vesicle fluid
42 viral isolate
43 unknown
44 other

Performing Laboratory Type

1=CDC lab
2=commercial lab
3=hospital lab
4=other clinical lab
5=public health lab
6=VPD reference centers
8=other
9=unknown

VACCINATION HISTORY

VACCINATED (has the 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 the 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 **U** = unknown
O = other (specify) ___________________

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

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
17 = vaccine not available

☐☐

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 pregnant at illness onset, weeks gestation? ☐☐

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

Is patient a healthcare worker? **Y**=yes **N**=no **U**=unknown ☐

Epi-linked to confirmed or probable case? **Y**=yes **N**=no **U**=unknown ☐

EPI-LINKAGE TYPE OF CASE

☐ Laboratory-confirmed varicella case
☐ Varicella cluster or outbreak containing ≥1 laboratory-confirmed case
☐ Herpes zoster case
☐ Probable case
☐ Unknown

TRANSMISSION SETTING

☐ Athletics	☐ College	☐ Community	☐ Correctional facility	☐ Day care	☐ Doctor's office
☐ Home	☐ Hospital ER	☐ Hospital outpatient	☐ Hospital ward	☐ International travel	☐ Military
☐ Place of worship	☐ School	☐ Work	☐ Other ___________	☐ Unknown	

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

OUTBREAK RELATED

Outbreak Related? **Y**=yes **N**=no **U**=unknown ☐

Outbreak Name ____

Was there at least one lab-confirmed case in the outbreak? **Y**=yes **N**=no **U**=unknown ☐

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 ☐			
Current Occupation _____		**Current Occupation Standardized** _____	
Current Industry _____		**Current Industry Standardized** _____	
Person Reporting to CDC _____ (first) **NAME** _____ (last)		**Person Reporting to CDC Email** _____ @ _____ **Person Reporting to CDC Phone Number** (__ __ __) __ __ __ __ __ __ __	

CLINICAL CASE DEFINITION ǂ

PROBABLE

- Meets clinical evidence with a generalized rash with vesicles,

OR

- Meets clinical evidence with a generalized rash without vesicles **AND**:
  - Confirmatory or presumptive epidemiologic linkage, **OR**
  - Supportive laboratory evidence.

OR

- Meets healthcare record criteria **AND**:
  - Confirmatory or presumptive epidemiologic linkage evidence, **OR**
  - Confirmatory or supportive laboratory evidence

CONFIRMED

- Meets clinical evidence **AND** confirmatory laboratory evidence,

OR

- Meets clinical evidence with a generalized rash with vesicles **AND** confirmatory epidemiologic linkage evidence.

ǂCSTE Position Statement at: https://cdn.ymaws.com/www.cste.org/resource/resmgr/ps/ps_2023/23-ID-09_Varicella.pdf