

Name _____ Hospital Record Number _____
LAST / FIRST / MIDDLE
Current Address _____ NUMBER / STREET / APT. NUMBER
CITY / COUNTY / STATE ZIP CODE
Telephone: Home _____ Work _____ AREA CODE + 7 DIGITS AREA CODE + 7 DIGITS
Reporting Physician/ Nurse/Hospital/ Clinic/Lab _____ ADDRESS _____ Telephone Number _____ AREA CODE + 7 DIGITS

Detach here — Transmit only lower portion if sent to CDC

VARICELLA DEATH INVESTIGATION WORKSHEET

Form Approved OMB No. 0920-0007 Exp. Date 7/31/2007

Reported by: State _____ Case Number _____

DEMOGRAPHIC DATA

1. Date of Birth [] [] [] [] [] [] [] [] MONTH DAY YEAR
2. Current Age [] [] [] (Unknown=999)
3. Age Type [] Years [] Days [] Hours [] Months [] Weeks [] Unknown
4. Current Sex [] Male [] Female [] Unknown
5. Ethnicity [] Hispanic [] Not Hispanic [] Unknown
6. Race [] American Indian or Alaska Native [] Asian [] Black or African-American [] Native Hawaiian or Other Pacific Islander [] White [] Other [] Unknown

7. Date of Death [] [] [] [] [] [] [] [] MONTH DAY YEAR
8. Country of Birth _____
9. If not born in the U.S., case lived in U.S. for [] [] years.
10. Occupation [] Healthcare Worker [] Teacher [] Day Care Worker [] Military Personnel [] College Student [] Staff in Institutional Setting (e.g., Correctional Facility) [] Other (specify) _____

MEDICAL HISTORY

Y=Yes N=No U=Unknown

11. History of varicella before this infection? [] Y [] N [] U
12. If yes, age at infection? [] [] [] (Unknown=999)
13. Age Type [] Years [] Days [] Hours [] Months [] Weeks [] Unknown
14. History of serologic evidence of immunity? [] Y [] N [] U
15. Varicella Vaccine History [] Vaccinated [] Not Vaccinated [] Unknown
16. If vaccinated Date Dose 1 [] [] [] [] [] [] [] [] MONTH DAY YEAR Date Dose 2 [] [] [] [] [] [] [] [] MONTH DAY YEAR
17. If not vaccinated, was there a contraindication to vaccination? [] Y [] N [] U If yes, specify _____
18. Type of contraindication [] Medical [] Philosophical [] Religious [] Other _____

19. Pre-existing conditions? [] Y [] N [] U (Check all that apply)
[] Cancer Type: _____
[] Transplant Recipient Organ: _____
[] Immune Deficiency Type: _____
[] Pregnancy
[] Chronic Renal Failure
[] Diabetes Mellitus
[] Tuberculosis
[] Asthma
[] Chronic Lung Disease Specify: _____
[] Chronic Dermatologic Disorder Specify: _____
[] Chronic Autoimmune Disease (e.g., Lupus, Rheumatoid Arthritis) Specify: _____
[] Other Specify: _____
20. For a child <1 year old, did his/her mother have a history of varicella? [] Y [] N [] U
21. For a child <1 year old, did his/her mother have a history of receipt of varicella vaccine? [] Y [] N [] U
22. Is this death the result of congenital varicella infection? [] Y [] N [] U
23. In the month prior to rash onset, did the decedent take any of the following?
Systemic Steroids [] Y [] N [] U Name of Steroid: _____ Dose: [] [] mg/day
Inhaled Steroids [] Y [] N [] U Name of Steroid: _____ Dose: [] [] mg/day
Other Systemic Medication [] Y [] N [] U List medication
1) _____ 3) _____
2) _____ 4) _____



Public reporting burden of this collection of information is estimated to average 2 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, 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/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-0007).

ILLNESS PRIOR TO DEATH

Y=Yes N=No U=Unknown

24. **Rash Onset Date**
MONTH DAY YEAR
25. **Was the rash generalized?** Y N U
26. **When first noted, did rash lesions seem to cluster on one side of the body?** Y N U
- If "yes," were lesions clustered on one limited area of the body involving no more than 3 dermatomes?** Y N U
- If "yes," which area? (check all that apply)**
- Face/Head
 Arms
 Legs
 Trunk
 Inside Mouth
 Other (Specify) _____

27. **Was the case hospitalized?** Y N U
- Admission Date**
MONTH DAY YEAR

If obtainable, please attach a copy of the hospital discharge summary.

COMPLICATIONS (check all that apply)

28. **Secondary Infection**
- From* Strep
 Group A beta-hemolytic
 Other type
 Unknown type
- Staph
 MRSA
 Other (Specify) _____
- Mixed
 Other (Specify) _____
- Type of Infection*
- Cellulitis
 Osteomyelitis
 Impetigo/Infected Skin Lesions
 Necrotizing Fasciitis
 Lymphadenitis
 Toxic Shock Syndrome
 Abscess
 Sepsis/Septicemia
 Septic Arthritis
 Other (Specify) _____

29. **Pneumonia/Pneumonitis**
Etiology, if known _____

30. **Neurologic Complications**
- Cerebellitis/Ataxia
 Encephalitis
 Other (Specify) _____

31. **Reye's Syndrome**

32. **Other (Specify)** _____

TREATMENT - MEDICATIONS (check all that apply)

33. **Acyclovir**
- Oral** Dose mg/day
Start Date
MONTH DAY YEAR
Duration days
- IV** Dose mg/day
Start Date
MONTH DAY YEAR
Duration days

34. **Famciclovir**
- Dose mg/day
Start Date
MONTH DAY YEAR
Duration days

35. **Valacyclovir**
- Dose mg/day
Start Date
MONTH DAY YEAR
Duration days

36. **Varicella Zoster Immune Globulin (VZIG)**
- Dose U's
Date Admin'd
MONTH DAY YEAR

37. **Aspirin**

38. **Non-Steroidal Anti-Inflammatory Drugs (i.e., ibuprofen)**

continues

39. Was laboratory testing done for varicella? If "yes": Y N U

40. Direct fluorescent antibody (DFA) technique? Y N U

Date of DFA
MONTH DAY YEAR

DFA Result Positive Pending
 Negative Not Done
 Indeterminate Unknown

41. PCR specimen? Y N U

Date of PCR Specimen
MONTH DAY YEAR

Source of PCR specimen: (check all that apply)
 Vesicular Swab Saliva
 Scab Blood
 Tissue Culture Urine
 Buccal Swab Macular Scraping
 Other _____

PCR Result Varicella Positive Not Done
 Varicella Negative Pending
 Indeterminate Unknown
 Other _____

Was the PCR specimen adequate (i.e., was it actin positive)? Y N U

42. Culture performed? Y N U

Date of Culture Specimen
MONTH DAY YEAR

Culture Result Positive Pending
 Negative Not Done
 Indeterminate Unknown

43. Was other laboratory testing done? If "yes": Y N U

Specify Other Test Tzanck smear
 Electron microscopy

Date of Other Test
MONTH DAY YEAR

Other Lab Test Result Positive (results consistent with varicella infection)
 Negative Not Done
 Indeterminate Unknown
 Pending

Test Result Value _____

44. Serology performed? Y N U

45. IgM performed? If "yes": Y N U

Type of IgM Test Capture ELISA Unknown
 Indirect ELISA Other _____

Date IgM Specimen Taken
MONTH DAY YEAR

IgM Test Result Positive Pending
 Negative Not Done
 Indeterminate Unknown

Test Result Value _____

46. IgG performed? If "yes": Y N U

Type of IgG Test:

Whole Cell ELISA (specify manufacturer): _____

gp ELISA (specify manufacturer): _____

FAMA Latex Bead Agglutination

Other _____

Date of IgG-Acute
MONTH DAY YEAR

IgG-Acute Result Positive Pending
 Negative Not Done
 Indeterminate Unknown

Test Result Value _____

Date of IgG-Convalescent
MONTH DAY YEAR

IgG-Conv. Result Positive Pending
 Negative Not Done
 Indeterminate Unknown

Test Result Value _____

47. Were the clinical specimens sent to CDC for genotyping (molecular typing)? If "yes": Y N U

Date sent for genotyping
MONTH DAY YEAR

48. Was specimen sent for strain (wild- or vaccine-type) identification? Y N U

Strain Type Wild Type Strain
 Vaccine Type Strain
 Unknown

49. Any herpes simplex virus testing performed? If "yes": Y N U

Type of Test _____

Date of Other Test
MONTH DAY YEAR

Test Result Positive Pending
 Negative Unknown
 Indeterminate

It can be difficult to distinguish varicella from disseminated herpes zoster (shingles). Serum or blood obtained from the decedent prior to or early in illness (i.e., weeks before to ~4 days after rash onset) could be used to test for evidence of prior varicella infection, which could sometimes help distinguish these two conditions. **If there is doubt whether the cause of death was related to varicella or to disseminated herpes zoster, an effort should be made as soon as possible to determine whether any such blood or serum specimens may be available.** For instance, serum specimens at hospital laboratories or a blood banks may be retained for many weeks.

HOSPITAL DISCHARGE

Y=Yes N=No U=Unknown

50. Discharge summary information available? Y N Ud. _____ . 51. Varicella included among diagnoses? Y N Ue. _____ . 52. Discharge Diagnoses **ICD-9 Code**f. _____ . a. _____ . g. _____ . b. _____ . h. _____ . c. _____ . i. _____ . j. _____ . **POST-MORTEM EXAM**

Y=Yes N=No U=Unknown

53. Post-mortem exam done? Y N U54. Varicella included among diagnoses? Y N U

55. If evidence of varicella, significant findings related to varicella-zoster virus infection, by organ system:

a. Organ _____

Findings _____

b. Organ _____

Findings _____

c. Organ _____

Findings _____

d. Organ _____

Findings _____

e. Organ _____

Findings _____

f. Other _____

DEATH CERTIFICATE

Y=Yes N=No U=Unknown

56. Death certificate available? Y N U57. Varicella included as one cause of death? Y N U58. Cause of Death **ICD-9 Code**a. _____ . b. _____ . c. _____ . d. _____ . **Contributing Conditions****ICD-9 Code**a. _____ . b. _____ . c. _____ . d. _____ . **SOURCE**

Y=Yes N=No U=Unknown

59. Case had close contact with a person with known or suspected infection 10-21 days before rash onset? Y N U60. Source had Shingles Varicella Unknown61. Current Age (Unknown=999)62. Age Type Years Days Hours
 Months Weeks Unknown63. Varicella vaccine history of source Source vaccinated
 Source not vaccinated64. If not vaccinated, source had contraindication to vaccination? Y N U
If yes, specify _____65. Transmission Setting (Setting of Exposure)
 Athletics Hospital Outpatient Clinic
 College Hospital Ward
 Community International Travel
 Correctional Facility Military
 Daycare Place of Worship
 Doctor's Office School
 Home Work
 Hospital ER Unknown
 Other _____66. If transmission was in the home
 Transmission from family member by adoption
 Transmission from family member biologically related67. Any international travel in the 4 weeks prior to illness? Y N U

If yes, what dates? _____

What country(ies)? _____