VARICELLA (CHICKENPOX) INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐ years ☐ months Current Sex: ☐ Female ☐ Male ☐ Unknown

Is the patient deceased? ☐ No ☐ Unknown ☐ Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐ Open ☐ Closed Investigator:_____

REPORTING INFORMATION

State Case ID: _____

Reporting Physician/Nurse: _____ Reporting Source: _____

Date of Report: __ __ / __ __ /__ __ __ __ Earliest Date Reported to: County: __ __ / __ __ /__ __ __ __ State: __ __ / __ __ /__ __ __ __

CLINICAL INFORMATION

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Which diagnosis did physician make? ☐ Chickenpox (varicella) ☐ Shingles (zoster)

Rash Onset Date: __ __ / __ __ /__ __ __ __ Rash Location: ☐ Focal ☐ Generalized ☐ Unknown

If Focal, Dermatome: _____

If Generalized, Location First Noted (Select all that apply): ☐ Arms ☐ Face/Head ☐ Inside Mouth ☐ Legs ☐ Other:_____ ☐ Trunk

Total number of lesions: ☐ <50 ☐ >500 ☐ 250-499 ☐ 50-249 Number of lesion (if < 50): _____

Macules (flat) present: ☐ No ☐ Unknown ☐ Yes Number of Macules: _____

Papules (raised) present: ☐ No ☐ Unknown ☐ Yes Number of Papules: _____

Vesicles (fluid) present: ☐ No ☐ Unknown ☐ Yes Number of Vesicles: _____

Character of lesions (all categories 1 to > 500):

Mostly Macular/Papular: ☐ No ☐ Unknown ☐ Yes Hemorrhagic: ☐ No ☐ Unknown ☐ Yes Crops/Waves: ☐ No ☐ Unknown ☐ Yes

Mostly Vesicular: ☐ No ☐ Unknown ☐ Yes Itchy: ☐ No ☐ Unknown ☐ Yes Scabs: ☐ No ☐ Unknown ☐ Yes

Did the rash crust: ☐ No ☐ Unknown ☐ Yes Number of days until all lesions crusted over: _____ Number of days rash lasted: _____

Did the patient have a fever: ☐ No ☐ Unknown ☐ Yes

Fever Onset: __ __ / __ __ /__ __ __ __ Highest Temp: _____°F Total number of days with fever: _____

Is the patient Immunocompromised due to medical condition or treatment: ☐ No ☐ Unknown ☐ Yes

Specify medical condition or treatment: _____

Did the patient visit a healthcare provider during the illness: ☐ No ☐ Unknown ☐ Yes

Did the patient develop any complication that were diagnosed by a healthcare provider: ☐ No ☐ Unknown ☐ Yes

Skin/Soft Tissue Infection: ☐ No ☐ Unknown ☐ Yes Dehydration: ☐ No ☐ Unknown ☐ Yes

Cerebellitis/Ataxia: ☐ No ☐ Unknown ☐ Yes Hemorrhagic Condition: ☐ No ☐ Unknown ☐ Yes

Encephalitis: ☐ No ☐ Unknown ☐ Yes Pneumonia: ☐ No ☐ Unknown ☐ Yes

How was pneumonia diagnosed: ☐ Medical Doctor (MD) ☐ Unknown ☐ X-ray

Other Complications: ☐ No ☐ Unknown ☐ Yes Specify "Other Complications": _____

Was the patient treated with acyclovir, famvir, or any licensed antiviral for this illness: ☐ No ☐ Unknown ☐ Yes

Name of Medication: ☐ Acyclovir ☐ Famvir ☐ Other ☐ Valacyclovir ☐ Other Medication: _____

Start Date of Medication: __ __ / __ __ /__ __ __ __ Stop Date of Medication: __ __ / __ __ /__ __ __ __

Was the patient hospitalized for this illness: ☐ No ☐ Unknown ☐ Yes Total duration of stay in the hospital (in days): _____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __

Hospital Information: _____

Did the patient die from varicella or complications (including secondary infection)? ☐ No ☐ Unknown ☐ Yes

Date of Death: __ __ / __ __ /__ __ __ __ Autopsy performed: ☐ No ☐ Unknown ☐ Yes Cause of Death: _____

LABORATORY INFORMATION

Was laboratory testing done for varicella? ☐ No ☐ Unknown ☐ Yes

Direct fluorescent antibody (DFA) testing performed? ☐ No ☐ Unknown ☐ Yes Date of DFA: __ __ / __ __ /__ __ __ __

DFA Result: ☐ Indeterminate ☐ Negative ☐ Not Done ☐ Pending ☐ Positive ☐ Unknown

Polymerase Chain Reaction (PCR) specimen? ☐ No ☐ Unknown ☐ Yes Date of PCR Specimen: __ __ / __ __ /__ __ __ __

Source of PCR Specimen (Select all that apply): ☐ Blood ☐ Buccal swab ☐ Macular scraping ☐ Other _____

☐ Saliva ☐ Scab ☐ Tissue culture ☐ Urine ☐ Vesicluar scab

PCR Result: ☐ Indeterminate ☐ Negative ☐ Not Done ☐ Other_____ ☐ Pending ☐ Positive ☐ Unknown

Culture performed? ☐ No ☐ Unknown ☐ Yes Date of Culture: __ __ / __ __ /__ __ __ __

Culture Result: ☐ Indeterminate ☐ Negative ☐ Not Done ☐ Pending ☐ Positive ☐ Unknown

Other Laboratory testing performed? ☐ No ☐ Unknown ☐ Yes

Specify Other Test: ☐ Electron microscopy ☐ Tzanck smear Date of Other Test: __ __ / __ __ /__ __ __ __

Culture Result: ☐ Indeterminate ☐ Negative ☐ Not Done ☐ Pending ☐ Positive ☐ Unknown Other Test result value: _____

Serology performed? ☐ No ☐ Unknown ☐ Yes

IgM performed: ☐ No ☐ Unknown ☐ Yes Type of IgM Test: ☐ Capture ELISA ☐ Indirect ELISA ☐ Other _____ ☐ Unknown

IgM Collection Date: __ __ / __ __ /__ __ __ __ IgM Result: ☐ Indeterminate ☐ Negative ☐ Not Done ☐ Pending ☐ Positive ☐ Unknown

IgM Test result value: _____

IgG performed: ☐ No ☐ Unknown ☐ Yes Type of IgG Test: ☐ FAMA ☐ gp ELISA, manufacturer MERCK ☐ Latex Bead Agglutination

☐ Other _____ ☐ Whole Cell ELISA, manufacturer _____

Acute IgG Collection Date: __ __ / __ __ /__ __ __ __

Acute IgG Result: ☐ Indeterminate ☐ Negative ☐ Not Done ☐ Pending ☐ Positive ☐ Unknown Acute IgG Test result value: _____

Convalescent IgG Collection Date: __ __ / __ __ /__ __ __ __

Convalescent IgG Result: ☐ Indeterminate ☐ Negative ☐ Not Done ☐ Pending ☐ Positive ☐ Unknown Conv. IgG Test result value: _____

Were specimens sent to CDC for genotyping (molecular typing)? ☐ No ☐ Unknown ☐ Yes Date sent to CDC: __ __ / __ __ /__ __ __ __

Was specimen sent for strain (wild or vaccine-type) identification? ☐ No ☐ Unknown ☐ Yes

Strain Type: ☐ Unknown ☐ Vaccine Type Strain ☐ Wild Type Strain

VARICELLA-CONTAINING VACCINE INFORMATION

Did the patient receive Varicella-containing vaccine? ☐ No ☐ Unknown ☐ Yes

If No, Reason why patient did not receive varicella-containing vaccine:

☐ Born outside the United States ☐ Lab evidence of previous disease ☐ MD diagnosis of previous disease

☐ Medical contraindication ☐ Never offered vaccine ☐ Other _____

☐ Parent/Patient forgot to vaccinate ☐ Parent/Patient refusal ☐ Parent/Patient report of previous disease

☐ Philosophical objection ☐ Religious exemption ☐ Under age for vaccination ☐ Unknown

Number of doses received on or after first birthday: _____

Reason patient is ≥ 6 years old and received one dose on or after 6th birthday but never received second dose:

☐ Born outside the United States ☐ Lab evidence of previous disease ☐ MD diagnosis of previous disease

☐ Medical contraindication ☐ Never offered vaccine ☐ Other _____

☐ Parent/Patient forgot to vaccinate ☐ Parent/Patient refusal ☐ Parent/Patient report of previous disease

☐ Philosophical objection ☐ Religious exemption ☐ Under age for vaccination ☐ Unknown

Based on the person's age and current recommendations, has the case received the recommended doses of vaccine? ☐ No ☐ Unknown ☐ Yes

VACCINE RECORD

1st Vaccination Date: __ __ / __ __ /__ __ __ __ Vaccine: ☐ MMRV ☐ Varicella Manufacturer: Merck Lot Number: _____

2nd Vaccination Date: __ __ / __ __ /__ __ __ __ Vaccine: ☐ MMRV ☐ Varicella Manufacturer: Merck Lot Number: _____

3rd Vaccination Date: __ __ / __ __ /__ __ __ __ Vaccine: ☐ MMRV ☐ Varicella Manufacturer: Merck Lot Number: _____

4th Vaccination Date: __ __ / __ __ /__ __ __ __ Vaccine: ☐ MMRV ☐ Varicella Manufacturer: Merck Lot Number: _____

5th Vaccination Date: __ __ / __ __ /__ __ __ __ Vaccine: ☐ MMRV ☐ Varicella Manufacturer: Merck Lot Number: _____

EPIDEMIOLOGIC INFORMATION

Patient History

Has this **Patient** ever been diagnosed with varicella before: ☐ No ☐ Unknown ☐ Yes

Age at Diagnosis: _____ ☐ days ☐ hours ☐ minutes ☐ months ☐ unknown ☐ weeks ☐ years

Previous case diagnosed by: ☐ Other _____ ☐ Parent/Friend ☐ Physician/Health Care Provider

Where was the patient born (country): ☐ United States ☐ Other Country _____

Epi-Link

Is this case **Epi-linked** to another confirmed or probable case: ☐ No ☐ Unknown ☐ Yes

Type of case this case is epi-linked to: ☐ Confirmed Varicella Case ☐ Herpes Zoster Case ☐ Probable Varicella Case

Transmission Setting (Setting of Exposure): ☐ Athletics ☐ College ☐ Community ☐ Correctional Facility

☐ Daycare ☐ Doctor`s Office ☐ Home ☐ Hospital ER

☐ Hospital Outpatient Clinic ☐ Hospital Ward ☐ International Travel ☐ Military

☐ Other _____ ☐ Place of Worship ☐ School ☐ Unknown ☐ Work

Is this case a healthcare worker? ☐ No ☐ Unknown ☐ Yes

Is this case part of an outbreak of 5 or more cases? ☐ No ☐ Unknown ☐ Yes Outbreak Name: _____

Exemptions at institution: ☐ No ☐ Unknown ☐ Yes Religious: _____ Medical: _____

If Transmission Setting is a school or daycare, is this patient associated with a day care facility? ☐ No ☐ Unknown ☐ Yes

Name of school or daycare: _____ City: _____ County: _____

What grades attend the school (i.e., K-12, K-6, 7-12, 7-8): _____

What grade is the case in at the school? ☐ Pre-kindergarten ☐ Kindergarten ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th

☐ Does not attend the school ☐ Unknown ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

Are there other cases in the classroom or other cases in the school building, or both? Explain: _____

Case Status

Case Status: ☐ Confirmed ☐ Not a Case ☐ Probable ☐ Suspect ☐ Unknown MMWR Week: _____ MMWR Year:_____

Pregnant Women

Was the **Patient Pregnant** during this varicella illness? ☐ No ☐ Unknown ☐ Yes

Number of weeks gestation at onset of illness (1-45 weeks): _____ Trimester at Onset: ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester

GENERAL COMMENTS

_____

_____

_____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐ Reviewed (Complete) ☐ Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐ Reviewed (Not a case) ☐ Yes

Review comments (completed by supervisor):_____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ 2nd Attempt: __ __ / __ __ /__ __ __ __ 3rd Attempt: __ __ / __ __ /__ __ __ __

Patient Contact Date(s):

1st Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM 2nd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

3rd Attempt: __ __ / __ __ /__ __ __ __ Time: _____ ☐ AM ☐ PM

Regular Letter Mailed: __ __ / __ __ /__ __ __ __ Certified Letter Mailed: __ __ / __ __ /__ __ __ __

Was clinical information obtained from the physician or patient? ☐ Yes ☐ No

IF NO CLINICAL INFORMATION AVAILABLE, STOP HERE. OTHERWISE CONTINUE INVESTIGATION.

CASE CLASSIFICATION

1	Did the patient have acute illness with diffuse (generalized) maculopapulovesicular rash?	☐ No ☐ Unknown ☐ Yes
2	Is there laboratory confirmation by any of the following: ☐ Isolation of varicella virus from a clinical specimen ☐ Varicella antigen detected by direct fluorescent antibody (DFA) test ☐ Varicella-specific nucleic acid detected by polymerase chain reaction (PCR) ☐ Significant rise in serum anti-varicella immunoglobulin G (IgG) antibody level by any standard serologic assay	☐ No ☐ Unknown ☐ Yes
3	Is the patient epidemiologically linked to another probable or confirmed case?	☐ No ☐ Unknown ☐ Yes
Confirmed: 1 & 2 or 1 & 3		**Probable: 1 only**