

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

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) \_\_\_\_\_



Department of Health and Human Services Centers for Disease Control and Prevention



**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				Yes	N=No	U=Unknown
50. Discharge summary information available?	Y	N	U			
51. Varicella included among diagnoses?	Y	N	U			
52. Discharge Diagnoses	ICD-9 Code					
a. _____						
b. _____						
c. _____						
				d.	_____	
				e.	_____	
				f.	_____	
				g.	_____	
				h.	_____	
				i.	_____	
				j.	_____	

POST-MORTEM EXAM				Y=Yes	N=No	U=Unknown
53. Post-mortem exam done?	Y	N	U			
54. 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	U			
57. Varicella included as one cause of death?	Y	N	U			
58. Cause of Death	ICD-10 Code					
a. _____						
b. _____						
c. _____						
d. _____						
				Contributing Conditions		ICD-10 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	U			
60. Source had	Shingles	Varicella	Unknown			
61. Current Age	(Unknown=999)					
62. Age Type	Years	Days	Hours			
	Months	Weeks	Unknown			
63. Varicella vaccine history of source	Source vaccinated Source not vaccinated					
64. 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 related					
67. Any international travel in the 4 weeks prior to illness?	Y	N	U			
If yes, what dates? _____						
What country(ies)? _____						