

# VARICELLA (CHICKEN POX) CASE REPORT

**Note: For Varicella deaths, please use CDC Varicella death work sheet.**

## PATIENT DEMOGRAPHICS

Patient name—last	first	middle initial	Date of birth ____/____/____	Age (enter age and check one) <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number, street)			City	State	ZIP code
ETHNICITY (check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown					

RACE (check all that apply)

<input type="checkbox"/> Unknown	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> African-American or Black	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Native Hawaiian
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Guamanian
<input type="checkbox"/> White	<input type="checkbox"/> Chinese	<input type="checkbox"/> Samoan
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Filipino	<input type="checkbox"/> Other Pacific Islander: _____
<input type="checkbox"/> Hmong	<input type="checkbox"/> Japanese	<input type="checkbox"/> Thai
<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Other Asian: _____		

Occupation (check all that apply)

Food service  Health care  Day care  School  Correctional facility  Other: \_\_\_\_\_

Country of birth \_\_\_\_\_ Country of residence \_\_\_\_\_

## COMMON LHD TRACKING DATA

CMRID number	IZB Case ID number	Web CMR ID number
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case
Case investigator completing form	Investigator telephone ( )	Investigator's LHD or jurisdiction

## SIGNS AND SYMPTOMS

Maculopapular rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rash onset date ____/____/____	Generalized rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direction of spread
Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other symptoms		Date of diagnosis ____/____/____
Does case meet clinical criteria for further investigation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>CASE MEETS CDC/CSTE CLINICAL CRITERIA? (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

## COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of days hospitalized	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cerebellar ataxia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other complications				Date of death ____/____/____

## LABORATORY TESTS

Any lab tests done for varicella? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>CASE LAB CONFIRMED (FOR LHD USE)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>CASE LAB CONFIRMED (FOR STATE USE ONLY)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
DFA performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	DFA specimen date ____/____/____	DFA result <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U		<b>LAB RESULT CODES</b> P = Positive (evidence of recent or current infection) N = Negative (antibody not detected) I = Indeterminate E = Pending X = Not done U = Unknown Z = Infection at undetermined time or immunization	
PCR performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PCR specimen date ____/____/____	PCR result <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U			
Virus isolation performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Virus specimen date ____/____/____	Virus isolated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of Lab: _____		
Specimen sent to CDC for genotyping <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date sent for genotyping ____/____/____	Virus genotype			
Specimen sent to CDC for strain typing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date sent for strain typing ____/____/____	Strain type <input type="checkbox"/> Wild-type <input type="checkbox"/> Vaccine-type			
Serology performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen Date	Titer Result	Test Reference Index	Result Interpretation	
IgM	____/____/____			<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U	
IgG (acute)	____/____/____			<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U <input type="checkbox"/> Z	
IgG (convalescent)	____/____/____			<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U <input type="checkbox"/> Z	
Other lab tests completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specify lab tests		Other lab test results		

**VACCINATION/MEDICAL HISTORY**

Received one or more doses of varicella containing vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of doses	Dates of vaccination Dose 1: ____/____/_____ Dose 2: ____/____/_____	
Reason for not being vaccinated ( <i>check one</i> ):			
1 <input type="checkbox"/> Personal Beliefs Exemption (PBE)	4 <input type="checkbox"/> Lab confirmation of previous disease	7 <input type="checkbox"/> Delay in starting series or between doses	
2 <input type="checkbox"/> Permanent Medical Exemption (PME)	5 <input type="checkbox"/> MD Diagnosis of previous disease	8 <input type="checkbox"/> Other	
3 <input type="checkbox"/> Temporary Medical Exemption	6 <input type="checkbox"/> Underage for vaccination	9 <input type="checkbox"/> Unknown	
Prior MD diagnosed varicella (see reason #5 above) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**EXPOSURE/TRAVEL HISTORY**

Acquisition setting (*check all that apply*):

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional Facility	15 <input type="checkbox"/> Other

Close contact with person(s) with rash 14–21 days before rash onset?  Yes  No  Unknown

#	Name	Rash Onset Date	Relationship	Age (Years)	Same Household
1					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing work sheet.

Epi-linked to a confirmed or probable case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case name or Case ID	Outbreak related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outbreak name or location
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**CONTACT INVESTIGATION**

Spread setting (*check all that apply*):

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional Facility	15 <input type="checkbox"/> Other

Number of susceptible contacts	Number of susceptible contacts who are pregnant	Close contacts who have rash 14–21 days after exposure to case <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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#	Name	Rash Onset Date	Relationship	Age (Years)
1				
2				
3				

Please list other contact(s) on a separate sheet or use the contact tracing work sheet.

<b>CASE CLASSIFICATION (FOR LHD USE)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown	<b>CASE CLASSIFICATION (FOR STATE USE ONLY)</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
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**VARICELLA CASE CLASSIFICATION**

Clinical Case Definition: An illness with acute onset of diffuse (generalized) papulovesicular rash without other apparent cause. Note: In vaccinated persons who develop varicella more than 42 days after vaccination (breakthrough disease), the disease is almost always mild with fewer than 50 skin lesions and shorter duration of illness. The rash may also be typical in appearance (maculopapular with few or no vesicles).

Case Classification:  
 Probable: A case that meets the clinical case definition is not laboratory confirmed, and is not epidemiologically linked to another probable or confirmed case.  
 Confirmed: A case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed or probable case. Note: Two probable cases that are epidemiologically linked are considered confirmed cases.