

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

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  Pending  
 Varicella Negative  Unknown  
 Indeterminate  
 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  Unknown  
 Indeterminate

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  Unknown  
 Indeterminate  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  Unknown  
 Indeterminate

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  Unknown  
 Indeterminate

Test Result Value \_\_\_\_\_

Date of IgG-Convalescent   /   /      
MONTH DAY YEAR

IgG-Conv. Result  Positive  Pending  
 Negative  Unknown  
 Indeterminate

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 Herpes Simplex Virus 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-10 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)? \_\_\_\_\_