

Varicella Surveillance Worksheet

Generic MMG Varicella MMG

NAME	ADDRESS (Street and No.)	Phone	Hospital Record No.
(last) _____ (first) _____	_____	_____	_____

This information will not be sent to CDC

REPORTING SOURCE TYPE [48766-0] NAME _____ <input type="checkbox"/> physician <input type="checkbox"/> PH clinic ADDRESS _____ <input type="checkbox"/> nurse <input type="checkbox"/> laboratory ZIP CODE [52831-5] _____ <input type="checkbox"/> hospital <input type="checkbox"/> other clinic PHONE (____) _____ <input type="checkbox"/> other source type _____	SUBJECT ADDRESS CITY [PID-11.3] _____ SUBJECT ADDRESS STATE [PID-11.4] _____ SUBJECT ADDRESS COUNTY [PID-11.9] _____ SUBJECT ADDRESS ZIP CODE [PID-11.5] _____ LOCAL SUBJECT ID [PID-3] _____
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CASE INFORMATION

Case Class Status [77990-0] <input type="checkbox"/> Suspected <input type="checkbox"/> Confirmed <input type="checkbox"/> Unknown <input type="checkbox"/> Probable <input type="checkbox"/> Not a case	Date First Reported [77995-9] _____ month day year	Date Reported to County [77972-8] _____ month day year	First Reported to PHD [77970-2] _____ month day year	Earliest Date Reported to State [77973-6] _____ month day year	Earliest Date Reported to County [77972-8] _____ month day year
Reporting State [77966-0] _____	Reporting County [77967-8] _____	National Reporting Jurisdiction [77968-6] _____	Age at Case Investigation [77998-3] _____ Age Unit* [OBX_6 for 77998-3] _____		
DATE OF BIRTH [PID_7] _____ month day year	SEX [PID_8] <input type="checkbox"/> M=male U=unknown F=female	RACE (select all that apply) [PID_10] <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused to answer <input type="checkbox"/> Not asked <input type="checkbox"/> Other [32624-9] _____ <input type="checkbox"/> Unknown			
Country of Birth [78746-5] _____	Other Birth Place [21842-0] _____	Country of Usual Residence [77983-5] _____ Ethnic Group [PID_22] _____ H=Hispanic or Latino N=not Hispanic/Latino O=other _____ U=unknown <input type="checkbox"/>			

Illness Onset Date [11368-8] _____ month day year	Illness End Date [77976-9] _____ month day year	Diagnosis Date [77975-1] _____ month day year	Illness Duration [77977-7] _____	Duration Units* [OBX_6 for 77977-7] _____	Pregnancy Status [77996-7] <input type="checkbox"/> Y=yes N=no U=unknown																																				
Rash Onset Date [81268-5] _____ month day year Body Regions of Rash [364402001]		Rash Duration [81269-3] _____ (days)	Was Rash Generalized? [725119006] Y=yes <input type="checkbox"/> N=no U=unknown	Total Number of Lesions [300579006] <input type="checkbox"/> <50 <input type="checkbox"/> 50-249 <input type="checkbox"/> 250-499 <input type="checkbox"/> 50-500 <input type="checkbox"/> >500 <input type="checkbox"/> Unknown																																					
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td>Arm, hand, torso, back</td><td></td></tr> <tr><td>Head/face with eye involvement</td><td></td></tr> <tr><td>Head/face without eye involvement</td><td></td></tr> <tr><td>Leg</td><td></td></tr> <tr><td>Neck/shoulder</td><td></td></tr> <tr><td>Pelvis/groin/buttocks/hip</td><td></td></tr> <tr><td>Submandibular salivary gland swelling</td><td></td></tr> <tr><td>Other (specify) _____</td><td></td></tr> </table>		Arm, hand, torso, back		Head/face with eye involvement		Head/face without eye involvement		Leg		Neck/shoulder		Pelvis/groin/buttocks/hip		Submandibular salivary gland swelling		Other (specify) _____		Character of Lesions [364637009] <input type="checkbox"/> Maculopapular <input type="checkbox"/> Vesicular <input type="checkbox"/> other _____ <input type="checkbox"/> unknown	If <50 Lesions, How Many? [246206008] <input type="checkbox"/> <input type="checkbox"/>	Were the Lesions: <table style="width:100%;"> <tr> <td></td> <td>yes</td> <td>no</td> <td>unk</td> </tr> <tr> <td>Hemorrhagic [INV911]</td> <td>Y</td> <td>N</td> <td>U</td> </tr> <tr> <td>Itchy [418290006]</td> <td>Y</td> <td>N</td> <td>U</td> </tr> <tr> <td>In crops/waves [NV912]</td> <td>Y</td> <td>N</td> <td>U</td> </tr> <tr> <td>Crust/scab over [INV913]</td> <td>Y</td> <td>N</td> <td>U</td> </tr> </table>			yes	no	unk	Hemorrhagic [INV911]	Y	N	U	Itchy [418290006]	Y	N	U	In crops/waves [NV912]	Y	N	U	Crust/scab over [INV913]	Y	N	U
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Did Patient Visit a Healthcare Provider During This Illness? [VAR128] <input type="checkbox"/> Y=yes N=no U=unknown		Fever ? [386661006] <input type="checkbox"/> Y=yes N=no U=unknown	Fever Onset Date [81266-9] _____ month day year	Highest Temperature [81265-1] _____ . _____ Temperature Units [OBX_6 for 81265-1] <input type="checkbox"/> °Cel <input type="checkbox"/> °F																																					
Patient Immunocompromised? [370388006] <input type="checkbox"/> Y=yes N=no U=unknown		Fever Duration [81264-4] _____	Immunocompromised-Associated Condition or Treatment [INV933] _____ <input type="checkbox"/> unknown																																						

*UNITS a=year h=hour mo=month w=week d=day min=minute s=second OTH=other UNK=unknown

COMPLICATIONS	Hospitalized? <input type="checkbox"/> [77974-4] Y=yes N=no U=unknown	Hospital Admission Date [8656-1] month day year	Hospital Discharge Date [8649-6] month day year	Duration of Hospital Stay [78033-8] 0 – 998 days <input type="text"/> <input type="text"/> <input type="text"/> 999=unknown days	Reason for Hospitalization [86947-9] <input type="checkbox"/> Varicella-related <input type="checkbox"/> IV treatment <input type="checkbox"/> Isolation <input type="checkbox"/> Non-varicella hospitalization <input type="checkbox"/> Observation <input type="checkbox"/> Other _____ <input type="checkbox"/> Severe varicella presentation <input type="checkbox"/> Unknown																												
	Subject Died? <input type="checkbox"/> [77978-5] Y=yes N=no U=unknown	Deceased Date [PID_29] month day year	Type of Complications [67187-5] Y N U <table border="1"> <tr><td>cerebellitis/ataxia</td><td></td><td></td><td></td></tr> <tr><td>dehydration</td><td></td><td></td><td></td></tr> <tr><td>hemorrhagic condition</td><td></td><td></td><td></td></tr> <tr><td>skin/soft tissue infection</td><td></td><td></td><td></td></tr> <tr><td>other</td><td></td><td></td><td></td></tr> <tr><td>pneumonia</td><td></td><td></td><td></td></tr> <tr><td>varicella encephalitis</td><td></td><td></td><td></td></tr> </table> Y=yes N=no U=unknown [INV920]			cerebellitis/ataxia				dehydration				hemorrhagic condition				skin/soft tissue infection				other				pneumonia				varicella encephalitis			
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Antiviral Medication? <input type="checkbox"/> [VAR139] Y=yes N=no U=unknown	Chest X_RAY for Pneumonia? [INV923] Y=yes N=no U=unknown D=not done																																

TREATMENT	Treatment Start Date [86948-7] month day year	Medication Received [29303-5] <input type="checkbox"/> acyclovir <input type="checkbox"/> famciclovir <input type="checkbox"/> valacyclovir LOGIC <input type="checkbox"/> other _____ <input type="checkbox"/> unknown	COMMENTS [77999-1]
	Treatment Duration [67453-1]		

LABORATORY TESTING

VPD Lab Message Reference Laboratory [LAB143]	VPD Lab Message Patient Identifier [LAB598]	VPD Lab Message Specimen Identifier [LAB125]	Laboratory Testing to Confirm Diagnosis? [LAB630] Y=yes N=no U=unknown <input type="checkbox"/>	Was Case Laboratory Confirmed? [LAB164] Y=yes N=no U=unknown <input type="checkbox"/>
			Specimen Sent to CDC? [82314-6] Y=yes N=no U=unknown <input type="checkbox"/>	

TEST TYPE	TEST RESULT	DATE SPECIMEN COLLECTED	DATE SPECIMEN SENT to CDC	TEST RESULT Quantitative	Result Units	SPECIMEN SOURCE	Performing Laboratory Type
[INV290]	T [INV291]	[68963-8]	[85930-6]	[LAB628]	[LAB115]	[31208-2]	[82771-7]
serology	IgM						
	IgG avidity						
	IgG (acute)						
	IgG (conv)						
	EIA						
	unspecified						
	culture						
	DFA						
	PCR						
	genotyping						
	other						
	strain ID						
	unknown						

TEST RESULTS CODES P=positive N=negative X=not done I=Indeterminate E=pending O=other (specify) IN=inadequate NS=no significant rise in IgG PS=significant rise in IgG U=unknown V=vaccine type strain W=wild type strain	Specimen Source Codes 1=blood 5=saliva 8=other (specify) 2=buccal swab 6=tissue 9=unknown 3=crust 7=urine 10=vesicular swab 4=macular scraping	Performing Laboratory Type 1=CDC lab 2=commercial lab 3=hospital lab 4=other clinical lab 5=public health lab 6=VPD testing lab 8=other 9=unknown
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VACCINATION HISTORY

VACCINATED? (Has the case-patient ever received Varicella-containing vaccine?) <input type="checkbox"/> Y=yes N=no U=unknown	Number Doses Received On or After First Birthday [VAC129] <input type="checkbox"/> 0-6 99 = unknown doses	Number Doses Received Prior to Illness Onset [82745-1] <input type="checkbox"/> 0-6 99=unknown	Date of Last Dose Prior to Illness Onset [VAC142] _____ month day year	VACCINATED per ACIP Recommendations? [VAC148] <input type="checkbox"/> Y=yes N=no U=unknown
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Vaccine Type**	Vaccination Date	Vaccine Manuff	Vaccine Lot Number	Vaccine Expiry Date	National Drug Code	Vaccination Record Identifier	Vaccine Event Information Source†	Vaccine Dose Number
[30956-7]	[30952-6] month day year	[30957-5]	[30959-1]	[VAC109] month day year	[VAC153]	[VAC102]	[VAC147]	[30973-2]

VACCINE TYPE** CODES [30956-7] M=measles/mumps/rubella/varicella [MMRV] V = varicella vaccine O = other (specify) _____ U= unknown	VACCINE MANUFACTURER† CODES [30957-5] M = Merck O = other (specify) _____ U = unknown	VACCINE EVENT INFORMATION SOURCE† CODES [VAC147] 00= new immunization record 01= historical information, source unidentified 02= historical information, other provider 05= historical information, other registry OTH= other _____ 06= historical information, birth certificate UNK= unknown 07= historical information, school record 08= historical information, public agency <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 09= historical information, patient or parent recall 10= historical information, patient or parent written record
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REASON NOT VACCINATED PER ACIP [VAC149]

1 = religious exemption	6 = too young	11 = vaccine record incomplete/unavailable
2 = medical contraindication	7 = parent/patient refusal	12 = parent/patient report of previous disease
3 = philosophical objection	8 = other _____	13 = parent/patient unaware of recommendation <input type="checkbox"/> <input type="checkbox"/>
4 = lab evidence of previous disease	9 = unknown	14 = missed opportunity 16 = immigrant
5 = MD diagnosis of previous disease	10 = parent/patient forgot to vaccinate	15 = foreign visitor

EPIDEMIOLOGIC	Diagnosed with Varicella Before? [VAR150] <input type="checkbox"/> Y=yes N=no U=unknown	Age at Previous Diagnosis [INV934] _____	Age Units§ [OBX-6 for INV934] _____	Is Case-Patient a HCW? [223366009] <input type="checkbox"/> Y=yes N=no U=unknown	Epi-Linked to Other Confirmed or Probable Case? [VAR154] <input type="checkbox"/> Y=yes N=no U=unknown	Epi-Linked Case Type [VAR155] O confirmed varicella O probable varicella O herpes zoster O unknown
	Previous Case Diagnosed By: [VAR152] O Parent O Physician/Healthcare provider O Other _____ O Unknown	Weeks Gestation at Illness Onset [81270-1] _____	Trimester at Illness Onset [81271-9] _____			
	IMPORTED CODE [77982-7] <input type="checkbox"/> 1=Indigenous 4=out of state 2=international 5=imported, unable to determine source 3=in state, out of jurisdiction 9=unknown	IMPORTED COUNTRY [INV153] _____	IMPORTED STATE [INV154] _____	IMPORTED CITY [INV155] _____	IMPORTED COUNTY [INV156] _____	

§UNITS a=year mo=month w=week d=day UNK=unknown

EXPOSURE INFORMATION	Outbreak Related? <input type="checkbox"/> Y=yes N=no U=unknown	Outbreak Name [77981-9]	TRANSMISSION SETTING [81267-7]	
	COUNTRY of Exposure [77984-3]	CITY of Exposure [77986-8]	1 = day care 6 = hospital outpatient 11 = military 15 = community 2 = school 7 = home 12 = correctional facility 16 = work 3 = doctor's office 8 = other _____ 17 = athletics 4 = hospital ward 9 = unknown 13 = church <input type="checkbox"/> <input type="checkbox"/> 5 = hospital ER 10 = college 14 = international travel	
	STATE/PROVINCE of Exposure [77985-0]	COUNTY of Exposure [77987-6]	TRANSMISSION MODE [77989-2] _____	

CASE NOTIFICATION	Condition Code [OBR_31] 10030	Local Record ID [OBR_3] _____	Legacy Case ID [77997-5] _____	State Case ID [77993-4] _____	Binational Reporting Criteria [77988-4] _____	Case Investigation Start Date [77979-3] _____ <small>month day year</small>	Case Investigation Status Code [INV109] <input type="checkbox"/> approved <input type="checkbox"/> deleted <input type="checkbox"/> closed <input type="checkbox"/> notified <input type="checkbox"/> in progress <input type="checkbox"/> ready for review <input type="checkbox"/> other _____ <input type="checkbox"/> rejected <input type="checkbox"/> reviewed <input type="checkbox"/> suspended <input type="checkbox"/> unknown
	Date First Verbal Notification to CDC [77994-2] _____ <small>month day year</small>	Date First Electronically Reported [OBR_7] _____ <small>month day year</small>	Date of Electronic Case Notification to CDC [OBR_22] _____ <small>month day year</small>	Person Reporting to CDC Phone No. [74548-9] _____ <small>Area code</small> _____			
	Jurisdiction Code [77969-4] _____	MMWR WEEK [77991-8] _____	MMWR YEAR [77992-6] _____	Immediate National Notifiable Condition [77965-2] <input type="checkbox"/> Y=yes N=no U=unknown	Person Reporting to CDC NAME [74549-7] _____ (first) _____ (last)		
	Current Occupation [85658-3] _____	Current Occupation Standardized [85659-1] _____	Current Industry [85078-4] _____	Current Industry Standardized [85657-5] _____	Person Reporting to CDC Email [74547-1] _____		

CLINICAL CASE DEFINITION ⁵⁵

PROBABLE

An acute illness with

- Diffuse (generalized) maculo-papulovesicular rash, **AND**
- Lack of laboratory confirmation, **AND**
- Lack of epidemiologic linkage to another probable or confirmed case.

CONFIRMED

An acute illness with diffuse (generalized) maculo-papulovesicular rash, **AND**

- Epidemiologic linkage to another probable or confirmed case, **OR**
- Laboratory confirmation by any of the following:
 - Isolation of varicella virus from a clinical specimen, **OR**
 - Varicella antigen detected by direct fluorescent antibody test, **OR**
 - Varicella-specific nucleic acid detected by polymerase chain reaction (PCR), **OR**
 - Significant rise in serum anti-varicella immunoglobulin G (IgG) antibody level by any standard serologic assay.

⁵⁵CSTE Position Statement 09-ID-68 <https://wwwn.cdc.gov/nndss/conditions/varicella/case-definition/2010/>