Varicella Death Investigation Worksheet

NAME (Last, First)			Hospital Record No.
Address (Street and No.)	City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic	Address		Phone

DETACH HERE and transmit only lower portion if sent to CDC

Varicella Death Investigation Worksheet

DEMOGRAPHIC DATA

CDC NETSS id | State | Case Number

Date of Birth (Month Day Year)

Age (Unk = 999)

Age Type
0 = 0-120 years
1 = 0-11 months
2 = 0-52 weeks
3 = 0-28 days
9 = Age unknown

Sex
M = Male
F = Female
U = Unknown

Race
N = Native Amer./Alaskan Native
A = Asian/Pacific Islander
B = African American
W = White
O = Other
U = Unknown

Ethnicity
H = Hispanic
N = Not Hispanic
U = Unknown

Date of Death (Month Day Year)

Country of Birth

If Not Born in U.S., Case Has Lived in U.S. For ____ Years

Occupation
H = Health Care Worker
T = Teacher
D = Day Care Worker
M = Military Personnel
S = Staff in Institutional Setting (e.g. Correctional facilities)
C = College Student
O = Other; Specify: _____

PAST MEDICAL HISTORY

History of Previous Varicella?
Y = Yes
N = No
U = Unknown

If Yes, Age When Ill
Age (Unk = 999)
Age Type: 0 = 0-120 years; 1 = 0-11 months; 2 = 0-52 weeks; 3 = 0-28 days; 9 = Age unknown

Varicella Vaccine History
V = Vaccinated
N = Not Vaccinated
U = Unknown

If Ever Vaccinated (Month Day Year)
Date 1
Date 2

If Not Vaccinated, Was there a Contraindication to Vaccination?
Y = Yes
N = No
U = Unknown
Specify: _____

Pre-Existing Condition?
Y = Yes
N = No
U = Unknown

(Check All That Apply)

- Cancer Type: _____
- Transplant Recipient Organ: _____
- Immune Deficiency Type: _____
- HIV+/AIDS
- Pregnancy
- Chronic Renal Failure
- Diabetes Mellitus
- Tuberculosis
- Asthma
- Chronic Lung Disease Specify: _____
- Chronic Dermatolgic Disorder Specify: _____
- Other Autoimmune Disease (e.g. Lupus, Rheumatoid Arthritis) Specify: _____
- Other Specify: _____

For Children < 1 Year Old, Did Their Mother Have a History of Previous Varicella?
Y = Yes
N = No
U = Unknown

Did The Decedent Take Any Drugs Listed in This Section During The Month Prior to Rash Onset?
Y = Yes
N = No
U = Unknown

(Check All That Apply)

- Steroids, Systemic — Name of Steroid: _____ Dose ____ mg/day
- Steroids, Inhaled
- Aspirin
- Chemotherapy
- Immunosuppressants

ILLNESS PRIOR TO DEATH

Rash Onset (Month Day Year)

Hospitalized?
Y = Yes
N = No
U = Unknown

Date Admitted (Month Day Year)

If Obtainable, Please Attach a Copy of the Hospital Discharge Summary

Complications (Check All That Apply)

- Secondary Infection — From: Strep (G = Group A Beta-hemolytic; O = Other Type; U = Unknown Type) Staph Mixed Other Specify: _____

Type of Infection:
Cellulitis; Impetigo/Infected Skin Lesions; Lymphadenitis; Abscess; Septic Arthritis; Osteomyelitis; Necrotizing Fasciitis; Toxic Shock Syndrome; Sepsis/Septicemia; Other Specify: _____

- Pneumonia/Pneumonitis — Etiology, if Known: _____
- Neurologic Complications: Cerebellitis/Ataxia; Encephalitis; Other Specify: _____
- Reye Syndrome
- Congenital Varicella Syndrome
- Other Specify: _____

Treatment -- Medications (Check All That Apply)

	Dose mg/day	Date Started (Month Day Year)	Duration Days
Acyclovir — Oral			
And/Or — IV			
Famciclovir			
Valacyclovir			

- Varicella Zoster Immune Globulin (VZIG) — Dose ____ U's — Date Administered (Month Day Year)
- Aspirin
- Non-Steroidal Anti-inflammatory Drugs (e.g. ibuprofin)

Note: This form has 2 sides

---------- DETACH HERE ----------

LABORATORY DATA

Varicella Lab Testing? ☐
Y = Yes
N = No
U = Unknown

Serology ☐
M = IgM
G = IgG
N = Not Done
U = Unknown

Serology Results ☐
P = Positive
N = Negative
I = Indterminate
E = Pending
X = Not Done
U = Unknown

IgG Results:

	Date Specimen Collected Month	Day	Year	Titer
1st ("Acute")				
2nd ("Convalescent")				

Case Number (From Previous Page)

For Any Positive Test List Specimen and Date Collected

Rapid Diagnostic Test ☐
D = Direct Fluorescent Antibody (DFA)
O = Other
Specify: _____

	Date Collected Month	Day	Year
1st Specimen: _____			
2nd Specimen: _____			
3rd Specimen: _____			

Tzanck Smear ☐

Date Collected Month	Day	Year	Result
			☐ P = Positive N = Negative U = Unknown

For Any Positive Test List Specimen and Date Collected

Viral Culture ☐

	Date Collected Month	Day	Year
1st Specimen: _____			
2nd Specimen: _____			
3rd Specimen: _____			

Polymerase Chain Reaction (PCR) ☐

	Date Collected Month	Day	Year	Strain Identified
1st Specimen: _____				
2nd Specimen: _____				
3rd Specimen: _____				

W = Wild
V = Vaccine

HOSPITAL DISCHARGE DATA

Discharge Summary Information Available? ☐ Y = Yes N = No

Varicella Included Among Diagnoses? ☐ Y = Yes N = No

Discharge Diagnoses (Include ICD-9 Code If Available)

	Diagnosis	ICD-9 Code		Diagnosis	ICD-9 Code
#1:			#6:		
#2:			#7:		
#3:			#8:		
#4:			#9:		
#5:			#10:		

POST-MORTEM EXAM DATA

Post-Mortem Exam Done? ☐
Y = Yes
N = No
U = Unknown

Pathological Evidence of Varicella Noted? ☐
Y = Yes
N = No

If Evidence of Varicella, Significant Findings Related to Varicella-Zoster Virus Infection, by Organ System

	Organ	Findings
#1:		
#2:		
#3:		
#4:		
#5:		

Other: _____

DEATH CERTIFICATE

Death Certificate Available? ☐
Y = Yes
N = No

Varicella Included as One Cause of Death? ☐
Y = Yes
N = No

	Part I: Cause of Death	ICD-9 Code		Part II: Contributing Conditions	ICD-9 Code
#1:			#1:		
#2:			#2:		
#3:			#3:		
#4:			#4:		

SOURCE DATA

Source ☐
C = Close Contact With a Person With Known or Suspected Infection, 10-21 Days Before Rash Onset
U = Unknown

Source Had ☐
S = Shingles
V = Varicella
U = Unknown

Age of Source ☐
Unk = 999

Age Type ☐
0 = 0-120 years
1 = 0-11 months
2 = 0-52 weeks
3 = 0-28 days
9 = Age unknown

Varicella Vaccine History of Source ☐
V = Source Vaccinated
N = Source Not Vaccinated

If Not Vaccinated, Source Had Contraindication to Vaccination? ☐
Y = Yes
N = No
U = Unknown
Specify: _____

Suspected Transmission Setting ☐
1 = Home
2 = School (not College)
3 = College
4 = Work
5 = Church
6 = Military
7 = Perinatal/In Utero
8 = Doctor's Office
9 = Unknown
10 = Hospital, Inpatient
11 = Hospital, ER
12 = Other; Specify: _____

For Transmission Within The Home ☐
A = Transmission From Family Member by Adoption
B = Transmission From Family Member Biologically Related