VARICELLA (CHICKEN POX) HOSPITALIZED CASE REPORT

California Dept. of Public Health
Immunization Branch
850 Marina Bay Parkway
Building P, 2nd Floor, MS 7313
Richmond, CA 94804-6403

PATIENT DEMOGRAPHICS

Patient's name (*last, first, middle initial)* | DOB *(month /day /year)* / / | Age *(enter age and check one)* ☐ Days ☐ Weeks ☐ Months ☐ Years

Address *(number and street)* | City/town | State | Zip code | County

Country of birth ☐ USA ☐ Other Specify _____ ☐ Unknown | Date of arrival to USA / / | Gender ☐F ☐M ☐FTM ☐MTF ☐Other ☐Unknown

Race (check all that apply)
☐Black/African American
☐Native American/Alaskan
☐White
☐Unknown
☐Other _____
☐Asian *(please specify)*
☐Asian Indian ☐Hmong ☐Thai
☐Cambodian ☐Japanese ☐Vietnamese
☐Chinese ☐Korean ☐Other Asian _____
☐Filipino ☐Laotian
☐Pacific Islander (*please specify)*
☐Native Hawaiian
☐Guamanian
☐Samoan
☐Other Pacific Islander _____

Ethnicity (*check one)* ☐Hispanic/Latino ☐Non-Hispanic/Non-Latino ☐Unknown

Occupation | Occupation Setting *(check all that apply)* ☐ Health Care ☐ Day Care ☐ School ☐ Correctional Facility ☐ Other, specify: _____

COMMON LHD TRACKING DATA

CMRID number | IZB case ID number

Date reported to county / / | Date investigation started / / | Person/clinician reporting case | Reporter telephone ( )

Case investigator completing form | Investigator telephone ( ) | Investigator jurisdiction

CLINICAL INFO: SIGNS AND SYMPTOMS

Physician diagnosis *(select only one)* ☐Chickenpox ☐ Shingles (*If shingles, not reportable)* ☐ Unknown | Maculo-papulovesicular rash ☐Yes ☐No ☐Unknown | Rash onset / / | Diagnosis date / /

Spread of rash
☐Generalized rash
☐Localized rash (1-3 dermatomes)
☐Unknown

Location

Duration of rash

Total number of lesions ☐ Unknown
☐ Mild (<50 lesions)
☐ Mild/moderate (50-249 lesions)
☐ Moderate (250-499 lesions)
☐ Severe (≥500 lesions or complications)

Rash characteristics (*check all that apply*)
☐ Itchy ☐ Painful ☐Tingling or numbness
☐Lesions present in different stages (vesicles, crusted lesions)

Fever>100.4 ☐Yes ☐ No ☐ Unknown

Other symptoms ☐ Yes ☐No ☐Unknown Describe:

DOES CASE MEET CSTE CLINICAL CRITERIA? ☐ Yes ☐ No ☐ Unknown

HOSPITALIZATION/COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized *(≥24 hours)* ☐ Yes ☐ No ☐ Unknown | Total nights hospitalized

Admission date / / Discharge date / /

Name of hospital

Reasons for hospitalization (check all that apply)
☐ Severity
☐ Isolation
☐ Observation
☐ Varicella-related complication
☐ Non-varicella hospitalization with coincident varicella
☐ Unknown
☐ Administration of IV treatment
☐ Other, specify _____

Complications ☐Yes ☐ No ☐ Unknown
Encephalitis ☐Yes ☐ No ☐Unknown
Skin/soft tissue infection ☐Yes ☐ No ☐Unknown
Cerebellitis/Ataxia ☐Yes ☐ No ☐Unknown
Secondary bacterial infection? ☐Yes ☐ No ☐Unknown If yes, specify _____
Pneumonia ☐ Yes ☐ No ☐ Unknown
Meningitis ☐Yes ☐ No ☐Unknown
Hemorrhagic condition ☐Yes ☐ No ☐ Unknown
Dehydration/hypovolemia ☐Yes ☐ No ☐Unknown
Death ***(If yes, complete worksheet)*** ☐Yes ☐ No ☐Unknown Date / /
Specify other complications

VACCINATION / MEDICAL HISTORY

Received one or more doses of varicella containing vaccine
☐ Yes, self-reported ☐ No
☐ Yes, documented ☐ Unknown

Number of doses prior to illness onset

Dates of vaccination
Dose 1 / / ☐Date Unknown
Dose 2 / / ☐ Date Unknown
Dose 3 / / ☐ Date Unknown
Dose 4 / / ☐ Date Unknown

Reason for not being vaccinated *(check all that apply)*
☐ Personal Beliefs Exemption (PBE)
☐ Permanent Medical Exemption (PME)
☐ Temporary Medical Exemption
☐ Lab confirmation of previous disease
☐ MD diagnosis of previous disease
☐ Under age for vaccination
☐ Delay in starting series or between doses
☐ Unknown
☐ Other

Prior MD diagnosis of varicella ☐Yes ☐No ☐ Unknown
Prior MD diagnosis of shingles ☐Yes ☐No ☐ Unknown
Immunocompromised (*If yes, explain in comments)* ☐Yes ☐No ☐ Unknown
Pregnant If yes, estimated delivery date ☐Yes ☐No ☐ Unknown / /
Co-morbidities (If yes, specify in comments) ☐Yes ☐No ☐ Unknown
Antivirals taken (If yes, specify in comments) ☐Yes ☐No ☐ Unknown

Comments-specify co-morbidities, reason for immunocompromised status (list medications or conditions) and type of antiviral treatment

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LABORATORY INFO

Name of diagnostic laboratory		**CASE LAB CONFIRMED** *(FOR STATE USE ONLY)* ☐ Yes ☐ No ☐ Unknown		
DFA performed: ☐ Yes ☐ No ☐ Unknown	Source	DFA specimen date / /	DFA result ☐ P ☐ N ☐ I ☐ E ☐ X ☐ U	**LAB RESULT CODES** P = Positive; N = Negative *(antibody not detected)*; I = Indeterminate; E = Pending; X = Not done; U = Unknown
PCR performed ☐ Yes ☐ No ☐ Unknown	Source	PCR specimen date / /	PCR result ☐ P ☐ N ☐ I ☐ E ☐ X ☐ U	
Virus isolation performed ☐ Yes ☐ No ☐ Unknown	Source	Virus specimen date / /	Virus isolated ☐ Yes ☐ No ☐ Unknown	
Genotyping performed ☐ Yes ☐ No ☐ Unknown		Date sent / /	Genotype	

Serology performed ☐ Yes ☐ No ☐ Unknown	Specimen date	Titer result	Test reference index	Result interpretation
IgM	/ /			☐ P ☐ N ☐ I ☐ E ☐ X ☐ U
IgG *(acute)*	/ /			☐ P ☐ N ☐ I ☐ E ☐ X ☐ U
IgG *(convalescent)*	/ /			☐ P ☐ N ☐ I ☐ E ☐ X ☐ U

Other lab tests performed ☐ Yes ☐ No ☐ Unknown	Source	Other lab test date	Specify lab tests	Other lab test results
	Source	Other lab test date / /	Specify lab tests	Other lab test results

EPIDEMIOLOGIC INFO: Please report all contacts meeting the probable or confirmed case definitions on a separate Case Report Form.

Close contact with person(s) with rash OR shingles (zoster) 10-21 days before rash onset ☐ Yes ☐ No ☐ Unknown

Epi-linked to a lab-confirmed or probable case ☐ Yes ☐ No ☐ Unknown If yes, Name or Case ID:	Outbreak related ☐ Yes ☐ No ☐ Unknown	Outbreak name or location

SPREAD SETTING *(check all that apply)*

☐ Day care ☐ Hospital Ward ☐ Home ☐ Military ☐ Unknown
☐ School ☐ Hospital ER ☐ Work ☐ Correctional facility ☐ Other _____
☐ Doctor's office ☐ Outpatient hospital clinic ☐ College ☐ Church

Number of susceptible contacts | Close contacts who have rash 10-21 days after exposure to case ☐ Yes ☐ No ☐ Unknown

	Name	Rash onset	Pregnant (*Circle one*)	Estimated date of delivery	Age *(years)*	Same household (*Circle one*)	Prophylaxis
1		/ /	Y N U	/ /		Y N U	☐ VariZIG ☐ Vaccination ☐ None
2		/ /	Y N U	/ /		Y N U	☐ VariZIG ☐ Vaccination ☐ None
3		/ /	Y N U	/ /		Y N U	☐ VariZIG ☐ Vaccination ☐ None

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

CASE CLASSIFICATION *(FOR LHD USE)* ☐ Confirmed ☐ Probable ☐ Not a case ☐ Unknown	**CASE CLASSIFICATION** (*FOR STATE USE ONLY)* ☐ Confirmed ☐ Probable ☐ Not a case ☐ Unknown

VARICELLA (chickenpox) 2010 CASE DEFINITION CSTE Position Statement Number: 09-ID-68

Clinical Case Definition: An illness with acute onset of diffuse (generalized) maculo-papulovesicular rash without other apparent cause.
Case Classification:
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 (**criteria for diagnosis**) 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.