NBS Patient ID: _____

Varicella

Demographic Information

Residency: State: _____ County: _____ ZIP: _____
Date of birth: _____
Sex: ☐ Male ☐ Female
Hispanic or Latino in origin: ☐ Yes ☐ No ☐ Unknown
Race description

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other/Multiracial: _____
- ☐ White
- ☐ Unknown

Reporting Information

Date of report: _____
Reporting source: _____
Earliest date reported to county: _____ Earliest date reported to state: _____
Reporter: _____

Clinical Information

Physician: _____
Diagnosis date: _____
Illness onset date: _____ Illness end date: _____
Illness duration (days): _____ Age at illness onset: _____
Outcome:
☐ Case survived ☐ Death due to condition ☐ Death unrelated ☐ Unknown
Rash onset date: _____
Rash location:

- ☐ Generalized
- ☐ Focal (specify dermatome: _____)
- ☐ Unknown

Location first noted (Check all that apply.):
☐ Arms ☐ Face/head ☐ Inside mouth
☐ Legs ☐ Trunk ☐ Other (specify): _____
Number of lesions in total:

- ☐ <50
- ☐ 50 to 249
- ☐ 250 to 499
- ☐ ≥500
- ☐ 50 to 500
- ☐ Unknown

If <50, specify total number of lesions: _____
Macules (flat) present: ☐ Yes ☐ No ☐ Unknown
If yes, number of macules: _____
Papules (raised) present: ☐ Yes ☐ No ☐ Unknown
If yes, number of papules: _____
Vesicles (fluid) present: ☐ Yes ☐ No ☐ Unknown
If yes, number of vesicles: _____

NBS Patient ID: _____

Character of lesions (all categories – 1 to >500):

Mostly macular/papular:	☐ Yes	☐ No	☐ Unknown
Mostly vesicular:	☐ Yes	☐ No	☐ Unknown
Hemorrhagic:	☐ Yes	☐ No	☐ Unknown
Itchy:	☐ Yes	☐ No	☐ Unknown
Scabs:	☐ Yes	☐ No	☐ Unknown
Crops/waves:	☐ Yes	☐ No	☐ Unknown
Did the rash crust:	☐ Yes	☐ No	☐ Unknown

If yes, number of days until all lesions crusted over: _____

If no, number of days rash lasted: _____

When first noticed, did rash seem to cluster on one side of the body? ☐ Yes ☐ No ☐ Unknown

If yes, did lesions affect no more than three dermatomes? ☐ Yes ☐ No ☐ Unknown

Did the patient have a fever?

☐ Yes ☐ No ☐ Unknown

→ Date of fever onset: _____ Highest measured temperature: _____

Total number of days with fever: _____

Other symptoms (describe):

_____

_____

_____

Is the patient immunocompromised due to a medical condition or treatment? ☐ Yes ☐ No ☐ Unknown

If yes, specify medical condition or treatment: _____

Does the patient have any of the following underlying conditions? (Check all that apply.)

☐ AIDS
☐ Alcohol abuse
☐ Asthma
☐ Atherosclerotic cardiovascular disease (ASCVD)/CAD
☐ Burns
☐ Cerebral vascular accident (CVA)/stroke
☐ Cirrhosis/liver failure
☐ Cochlear implant
☐ Complement deficiency
☐ CSF leak (2 deg trauma/surgery)
☐ Current smoker
☐ Deaf/profound hearing loss
☐ Diabetes mellitus
☐ Emphysema/COPD
☐ Heart failure/CHF
☐ HIV
☐ Hodgkin's disease
☐ Immunoglobulin deficiency
☐ Immunosuppressive therapy (steroids, chemotherapy)
☐ Intravenous drug use (IVDU)
☐ Leukemia
☐ Multiple myeloma
☐ Nephrotic syndrome
☐ Obesity
☐ Organ transplant (specify): _____
☐ Other malignancy (specify): _____
☐ Renal failure/dialysis
☐ Sickle cell anemia
☐ Splenectomy/asplenia
☐ Systemic lupus erythematosus (SLE)
☐ Other (specify): _____
☐ None
☐ Unknown

NBS Patient ID: _____

Did the patient visit a healthcare provider during this illness? ☐ Yes ☐ No ☐ Unknown

Did the patient develop any complications that were diagnosed by a healthcare provider?

☐ Yes ☐ No ☐ Unknown

- Skin/soft tissue infection: ☐ Yes ☐ No ☐ Unknown
- Cerebellitis/ataxia: ☐ Yes ☐ No ☐ Unknown
- Encephalitis: ☐ Yes ☐ No ☐ Unknown
- Dehydration: ☐ Yes ☐ No ☐ Unknown
- Hemorrhagic condition: ☐ Yes ☐ No ☐ Unknown
- Secondary infection: ☐ Yes ☐ No ☐ Unknown
- Congenital varicella Syndrome (CVS): ☐ Yes ☐ No ☐ Unknown
- Neurological complications: ☐ Yes ☐ No ☐ Unknown
- Reyes syndrome: ☐ Yes ☐ No ☐ Unknown
- Pneumonia: ☐ Yes ☐ No ☐ Unknown
  - If yes, how was pneumonia diagnosed: ☐ Medical doctor (MD) ☐ X-ray ☐ Unknown
- Other complications: ☐ Yes ☐ No ☐ Unknown
  - Specify other complications: _____

Was the patient treated with acyclovir, famvir, or any licensed antiviral for this illness?

☐ Yes ☐ No ☐ Unknown

- Name of medication:
  - ☐ Acyclovir ☐ Famcyclovir ☐ Valacyclovir ☐ Other (specify): _____
  - ☐ Unknown
- Start date of medication: _____
- Stop date of medication: _____

Was the patient treated with antibiotics after onset? ☐ Yes ☐ No ☐ Unknown

If yes, were antibiotics halted after varicella diagnosis or viral confirmation? ☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized before or during the infection?

If yes, please contact ISDH so the investigation can be reassigned to a district field epidemiologist.

☐ Yes ☐ No ☐ Unknown

- Date admitted to the hospital: _____
- Date discharged from the hospital: _____
- Total duration of stay (days): _____
- Hospital name: _____
- Patient chart number: _____
- Reason for hospitalization (check all that apply):
  - ☐ Administration of IV treatment
  - ☐ Isolation
  - ☐ Non-varicella hospitalization
  - ☐ Observation
  - ☐ Severe varicella presentation
  - ☐ Varicella-related complications
  - ☐ Other (specify): _____

NBS Patient ID: _____

Was the patient seen in an emergency room?

☐ Yes
☐ No
☐ Unknown

- Date first seen in emergency room: _____
- Name of emergency room: _____

Did the patient die from varicella or complications (including secondary infection) associated with varicella?

If yes, please contact ISDH so the investigation can be reassigned to a district field epidemiologist.

☐ Yes ☐ No ☐ Unknown

- Date of death: _____
- Autopsy performed: ☐ Yes ☐ No ☐ Unknown
- Cause of death: _____

Laboratory Information

Was laboratory testing done for varicella?

☐ Yes ☐ No ☐ Unknown

If no or unknown, skip to "Vaccine Information" below.

Was direct fluorescent antibody (DFA) testing performed?

☐ Yes ☐ No ☐ Unknown

- Date of DFA specimen: _____
- DFA result: ☐ Positive ☐ Negative ☐ Intermediate ☐ Pending ☐ Not done ☐ Unknown

Was PCR testing performed?

☐ Yes ☐ No ☐ Unknown

- Date of PCR specimen: _____
- PCR specimen source: ☐ Blood ☐ Buccal swab ☐ Macular scraping ☐ Saliva ☐ Scab ☐ Tissue culture ☐ Urine ☐ Vesicular swab ☐ Other (specify): _____
- PCR result: ☐ Positive ☐ Negative ☐ Intermediate ☐ Pending ☐ Not done ☐ Unknown ☐ Other (specify): _____

Was culture performed?

☐ Yes ☐ No ☐ Unknown

- Date of culture specimen: _____
- Culture result: ☐ Positive ☐ Negative ☐ Intermediate ☐ Pending ☐ Not done ☐ Unknown

Was other laboratory testing (other than serology) done?

☐ Yes ☐ No ☐ Unknown

- Specify other test: _____
- Date of other test: _____
- Other lab test result: ☐ Positive ☐ Negative ☐ Intermediate ☐ Pending ☐ Not done ☐ Unknown
- Other test result value: _____

NBS Patient ID: _____

Serology performed:
☐ Yes ☐ No ☐ Unknown

IgM performed:
☐ Yes ☐ No ☐ Unknown
Type of IgM test: ☐ Capture ELISA ☐ Indirect ELISA ☐ Other ☐ Unknown
Date IgM specimen taken: _____
IgM test result: ☐ Positive ☐ Negative ☐ Intermediate ☐ Pending ☐ Not done ☐ Unknown
IgM test result value: _____

IgG performed:
☐ Yes ☐ No ☐ Unknown
Type of IgG test: ☐ FAMA ☐ gp ELISA ☐ Latex bead agglutination ☐ Whole cell ELISA ☐ Other (specify): _____
Date of IgG - acute: _____
IgG – acute result: ☐ Positive ☐ Negative ☐ Intermediate ☐ Pending ☐ Not done ☐ Unknown
IgG – acute test result value: _____
Date of IgG - convalescent: _____
IgG – convalescent result: ☐ Positive ☐ Negative ☐ Intermediate ☐ Pending ☐ Not done ☐ Unknown
IgG – convalescent test result value: _____

Were the specimens sent to the CDC for genotyping (molecular typing)?
☐ Yes ☐ No ☐ Unknown

Date sent for genotyping: _____
Was specimen genotyping completed at CDC? ☐ Yes ☐ No ☐ Unknown
What was the identified genotype? _____

Was the specimen sent for strain (wild- or vaccine-type) identification?
☐ Yes ☐ No ☐ Unknown
If yes, strain type: ☐ Vaccine type strain ☐ Wild type strain ☐ Unknown

Vaccine Information

Did the patient ever receive varicella-containing vaccine?
☐ Yes (Number of doses received on or after first birthday: _____)
☐ No
☐ Unknown

NBS Patient ID: _____

If the patient never received varicella-containing vaccine **or** if the patient is ≥ 6 years old and never received a second dose, specify the reason why not:

- ☐ Born outside the United States
- ☐ Foreign visitor
- ☐ Immigrant
- ☐ Lab evidence of previous disease
- ☐ MD diagnosis of previous disease
- ☐ Medical contraindication
- ☐ Missed opportunity in a medical setting
- ☐ Never offered vaccine
- ☐ Parent/Patient forgot to vaccinate
- ☐ Parent/Patient refusal
- ☐ Parent/Patient report of previous disease
- ☐ Parent/Patient unaware of recommendation
- ☐ Philosophical objection
- ☐ Religious exemption
- ☐ Too young
- ☐ Under age for vaccination
- ☐ Vaccine record incomplete/unavailable
- ☐ Unknown
- ☐ Other (specify): _____

If the patient ever received varicella-containing vaccine, enter vaccination information below.
Don't forget to also enter vaccine data into the investigation by adding the individual vaccine record under the EVENTS TAB in the PATIENT FILE.

Vaccination Date	Vaccine Type	Manufacturer	Lot Number	Provider/Organization

Epidemiologic Information

Has the patient ever been diagnosed with varicella before?

☐ Yes ☐ No ☐ Unknown

→ Age at diagnosis: _____ Units: _____

→ Previous case diagnosed by: ☐ Parent ☐ Parent/friend ☐ Physician/healthcare provider ☐ Other (specify): _____ ☐ Unknown

Where was the patient born? _____

Does the patient have serological evidence of immunity to varicella? ☐ Yes ☐ No ☐ Unknown

Is this case epi-linked to another confirmed or probable case?

☐ Yes ☐ No ☐ Unknown

→ Type of case this case is epi-linked to: ☐ Confirmed varicella case ☐ Herpes zoster case ☐ Probable varicella case ☐ Unknown

→ If epi-linked to other varicella cases, list all linked case IDs:
_____

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NBS Patient ID: _____

Transmission setting (setting of exposure):

- ☐ Athletics
- ☐ College
- ☐ Community
- ☐ Correctional facility
- ☐ Daycare
- ☐ Doctor's office
- ☐ Home
- ☐ Hospital ER
- ☐ Hospital outpatient clinic
- ☐ Hospital ward
- ☐ International travel
- ☐ Military
- ☐ Place of worship
- ☐ School
- ☐ Work
- ☐ Other (specify): _____
- ☐ Unknown

Is this case a healthcare worker? ☐ Yes ☐ No ☐ Unknown

Is this case part of an outbreak of 5 or more cases? ☐ Yes ☐ No ☐ Unknown

If yes, outbreak name/ID: _____

Is this patient associated with a daycare facility? ☐ Yes ☐ No ☐ Unknown

Is this patient a food handler? ☐ Yes ☐ No ☐ Unknown

Does this patient attend or work at a school (K-12)? ☐ Yes ☐ No ☐ Unknown

Contact information for school/daycare/employer:

_____
_____
_____
_____

Where was the disease acquired?

- ☐ Indigenous, within jurisdiction
- ☐ Out of country
- ☐ Out of state
- ☐ Out of jurisdiction, from another jurisdiction
- ☐ Unknown

If imported, specify:

Imported country: _____
Imported state: _____
Imported city: _____
Imported county: _____

Did the patient travel during the three weeks prior to symptom onset?
(Any travel – in-state, out-of-state, out-of-country.):

☐ Yes ☐ No ☐ Unknown

Travel locations and dates:

_____
_____
_____

Confirmation method:

- ☐ Active surveillance
- ☐ Case/outbreak investigation
- ☐ Clinical diagnosis (non-laboratory confirmed)
- ☐ Epidemiologically linked
- ☐ Laboratory confirmed
- ☐ Laboratory report
- ☐ Local/state specified
- ☐ Medical record review
- ☐ Occupational disease surveillance
- ☐ Provider certified
- ☐ Other (specify): _____
- ☐ No information given

NBS Patient ID: _____

Was the patient pregnant during this varicella illness?

☐ Yes ☐ No ☐ Unknown

- Number of weeks gestation at onset of illness: _____
- Trimester at onset of illness: ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ Unknown

Supplemental Demographic Information

I'd like to finish by asking you a series of questions about your background. These questions provide us with highly useful information about how different illnesses affect different groups of people.

We are asking these questions so we can target our efforts to prevent (*varicella)* in Indiana.

You can choose not to answer a question at any point. Any information you give me will be confidential and will not be released to outside of public health, including your medical care team and insurance provider. Do you have any questions?

What is the highest grade or year of school the patient completed? ☐ Declined to answer

- ☐ Never attended school/only attended kindergarten
- ☐ Elementary (grades 1 to 8)
- ☐ Some high school (grades 9 to 11)
- ☐ High school graduate (diploma or GED)
- ☐ Some college (1 to 3 years)
- ☐ Associate's or technical school degree (2 years)
- ☐ Bachelor's degree (4 years)
- ☐ Professional degree beyond bachelor's
- ☐ Unknown

What is the patient's current employment status? ☐ Declined to answer

- ☐ Employed for wages
- ☐ Homemaker
- ☐ Out of work - <1 year
- ☐ Out of work - 1+ years
- ☐ Retired
- ☐ Self-employed
- ☐ Student-employed
- ☐ Student-not employed
- ☐ Unable to work
- ☐ Unknown

What is the patient's current housing status? ☐ Declined to answer

- ☐ Single-family home
- ☐ Apartment
- ☐ Other: _____
- If apartment or single-family home, what is the household size? _____
- ☐ Barracks
- ☐ Boarding school
- ☐ Camp
- ☐ Communal living situation
- ☐ Correction facility
- ☐ Dormitory
- ☐ Long-term care
- ☐ Shelter
- ☐ Unknown

In the past 12 months, has the patient delayed receiving healthcare for any of the following reasons:

- ☐ No
- ☐ Clinic/office closed
- ☐ Couldn't phone
- ☐ Couldn't get appointment
- ☐ Long wait time
- ☐ No transportation
- ☐ Declined to answer

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NBS Patient ID: _____

What is the patient's annual household income from all sources in the past 12 months? ☐ Declined to answer

☐ <$15,000
☐ $15,000 to $24,999
☐ $25,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 or more

Investigation Information

How much of the investigation was completed?

☐ All questions asked ☐ Partial questions asked ☐ Unable to contact ☐ Not investigated

Was this case lost to follow-up?

☐ Yes ☐ No ☐ Unknown

General Comments