West Virginia Bureau for Public Health — Your Health Your Safety Our Purpose
Department of Health & Human Resources

Varicella (Chickenpox) Death

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade:_____ Employer/School:_____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: _____ *Phone:* _____

Birth date: __ / __ / ____ Age: _____
Gender: ☐Male ☐Female ☐Unk
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
Race: ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

Case's country of birth: _____ If not born in US, how long has case lived in US (in years): _____

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

REPORTING SOURCE

Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _____ Address: _____ _____ Phone: _____
Earliest date reported to county: __/__/____ Earliest date reported to state: __/__/____
Reporter Name: _____ ____ Address: _____ Phone: _____

CLINICAL

Physician Name: _____ Physician Facility : _____
Physician Address: _____ Phone: _____

Hospital Was patient hospitalized for this illness? ☐ **Y** ☐ **N** ☐ **U** If yes, Admit date: __ / __ / ____ Discharge date: __ / __ / ____
Hospital name: _____

Condition Diagnosis date: __/__/____ Illness onset date: __/__/____ Illness end date: __/__/____
Rash onset date: __/__/____ Rash type: ☐ Generalized ☐ Localized/dermatomal ☐ Unknown

Complications

Did patient experience a secondary infection? ☐ **Y** ☐ **N** ☐ **U**
If yes, check all that apply: ☐ Strep (specify below) ☐ Staph ☐ Mixed ☐ Other (specify): _____
If strep from above, specify: ☐ Group A Beta-hemolytic ☐ Other (specify): _____ ☐ Unknown type

If secondary infection, specify type (check all that apply):
☐ Abscess ☐ Osteomyelitis ☐ Lymphadenitis ☐ Toxic Shock Syndrome ☐ Impetigo/Infected skin lesion
☐ Cellulitis ☐ Sepsis/Septicemia ☐ Septic Arthritis ☐ Necrotizing Fasciitis ☐ Other (specify): _____

Other Complications (check all that apply):
☐ Congenital Varicella Syndrome ☐ Pneumonia/Pneumonitis (specify etiology if known): _____
☐ Reye Syndrome ☐ Other (specify): _____

Did the patient experience neurologic complications? ☐ **Y** ☐ **N** ☐ **U**
If yes, what type: ☐ Cerebellar Ataxia ☐ Encephalitis ☐ Other (specify): _____

TREATMENT

Medication	Taken	Dose	Date Started	Duration in Days
	Y N U	mg/day	mm/dd/yyyy	
Acyclovir Oral	☐ ☐ ☐			
Acyclovir IV	☐ ☐ ☐			
Famciclovir	☐ ☐ ☐			
Valacyclovir	☐ ☐ ☐			

Select other medications taken:
☐ Aspirin ☐ Non-steroidal anti-inflammatory drugs (e.g. ibuprofen) ☐ Immune Globulin Intravenous (IGIV) ☐ Other (specify): ___
If IGIV or "Other" given, date administered: __/__/____ Dose administered: _____ Dose units: _____ _____

CAUSE OF DEATH INFORMATION

Discharge summary information available? ☐ **Y** ☐ **N** ☐ **U**
Varicella included among diagnosis on discharge summary? ☐ **Y** ☐ **N** ☐ **U**

Discharge Diagnosis (include ICD-10 code if available)

Number	Diagnosis	ICD-10 Code
1.		
2.		
3.		
4.		
5.		

Was post-mortem exam done? ☐ **Y** ☐ **N** ☐ **U**
Pathological evidence of varicella noted? ☐ **Y** ☐ **N** ☐ **U**

If evidence of varicella, note significant findings related to Varicella-Zoster Virus infection by organ system

Number	Organ	Finding
1.		
2.		
3.		
4.		
5.		

Is a death certificate available? ☐ **Y** ☐ **N** ☐ **U**
Varicella included as one cause of death on death certificate? ☐ **Y** ☐ **N** ☐ **U**

Part 1. Cause of death on death certificate

Number	Cause of Death	ICD-10 Code
1.		
2.		
3.		
4.		
5.		

Part 2. Contributing Conditions on Death Certificate

Number	Cause of Death	ICD-10 Code
1.		
2.		
3.		
4.		
5.		

PAST MEDICAL HISTORY

History of previous varicella infection? ☐ **Y** ☐ **N** ☐ **U**
If yes, age when ill: _____ Age units: ☐ Days ☐ Weeks ☐ Months ☐ Years
Did the case have a pre-existing condition? ☐ **Y** ☐ **N** ☐ **U**
If yes, check all that apply:

☐ Asthma
☐ Tuberculosis
☐ Other (specify): _____
☐ Cancer (specify): _____
☐ Chronic dermatologic disorder (specify): _____
☐ Diabetes Mellitus
☐ Chronic Renal Failure
☐ Pregnancy
☐ HIV/AIDS
☐ Transplant recipient (organ): _____
☐ Other autoimmune disease (specify): _____
☐ Immune deficiency (specify): _____
☐ Chronic lung disorder (specify): _____

Did the decedent take any drug listed below during the month prior to rash onset? ☐ **Y** ☐ **N** ☐ **U**
If yes, check all that apply: ☐ Steroids, systemic ☐ Steroids, inhaled ☐ Aspirin ☐ Chemotherapy ☐ Immunosuppressants
If systemic steroids were taken: Name: _____ Dose (mg/day): _____

LABORATORY *(Please submit copies of all labs to DIDE)*

Was laboratory testing done for varicella? ☐ **Y** ☐ **N** ☐ **U** If yes, Date specimen collected: __/__/____
Serology testing: ☐ IgM ☐ IgG ☐ Not Done ☐ Unknown
Serology results: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not done ☐ Unknown

IgG Results

Test Type	Date Specimen Collected (mm/dd/yyyy)	Titer
1st (Acute)		
2nd (Convalescent)		

Were rapid diagnostic tests performed? ☐ **Y** ☐ **N** ☐ **U**
If yes, specify*: ☐ Direct Fluorescent Antibody (DFA) ☐ Viral Culture ☐ Polymerase Chain Reaction (PCR) ☐ Other (specify): ________ ____________________
* Complete information below for any positive test result

Test Type	Specimen Number	Specimen	Date Collected (mm/dd/yyyy)	Strain Identified (for PRC test)
☐ DFA ☐ PCR ☐ Viral Culture ☐ Other				☐ Wild ☐ Vaccine
☐ DFA ☐ PCR ☐ Viral Culture ☐ Other				☐ Wild ☐ Vaccine
☐ DFA ☐ PCR ☐ Viral Culture ☐ Other				☐ Wild ☐ Vaccine
☐ DFA ☐ PCR ☐ Viral Culture ☐ Other				☐ Wild ☐ Vaccine
☐ DFA ☐ PCR ☐ Viral Culture ☐ Other				☐ Wild ☐ Vaccine
☐ DFA ☐ PCR ☐ Viral Culture ☐ Other				☐ Wild ☐ Vaccine

Tzanck Smear Collection Date: __/__/____ ☐ Not done Tzanck Smear Results: ☐ Positive ☐ Negative ☐ Unknown ☐ Not done
Laboratory Name: ________________________________ Phone: ____________________ Fax: ____________________
Address: ____

VACCINE INFORMATION

Did the patient have a history of previous varicella infection? ☐ **Y** ☐ **N** ☐ **U**
If yes, age when they had varicella: _______ Age units: ☐ Days ☐ Weeks ☐ Months ☐ Years
Did the patient receive varicella vaccine? ☐ **Y** ☐ **N** ☐ **U**
If yes, number of doses: _____ Age at last dose: _______ Age units: ☐ Days ☐ Weeks ☐ Months ☐ Years
If not vaccinated, what was the reason: ☐ Religious exemption ☐ Medical contraindication ☐ Philosophical exemption
☐ Lab evidence of previous disease ☐ MD diagnosis
If patient < 1 year old, did their mother have a history of previous varicella disease? ☐ **Y** ☐ **N** ☐ **U**

VACCINATION RECORD

Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ Organization Name: ________________________________ Organization ID: _________________
Date received: __/__/____ Anatomical site: ________________ Vaccine administered: ______________ Vaccine ID: __________ Manufacturer: ________________ Organization ID: __________ Lot #: __________________ Expiration Date: __/__/____	**Given by:** Last Name: __________________________ First Name: _____________________ Provider ID: ___________ Organization Name: ________________________________ Organization ID: _________________

EPIDEMIOLOGIC

Y N U
☐ ☐ ☐ Is this case epi-linked to another case? If yes, case ID of epi-linked case: __________ (complete information below)
Last Name: ____________________________ First Name: ____________________________ DOB: __/__/____
County of residence: ______________________________ Onset Date: __/__/____
☐ ☐ ☐ Is this case part of a cluster or outbreak? If yes, name of outbreak? _________________

Transmission Setting (where did this case acquire varicella?):

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

For transmission in the home: ☐Transmitted from family member by adoption ☐ Transmitted from biologically related family member
Source: ☐ Close contact with a person with known or suspected infection 10-21 days before rash onset ☐ Unknown
Source had: ☐ Shingles ☐ Varicella ☐ Unknown
Varicella Vaccine History of Source: ☐ Vaccinated ☐ Not vaccinated
If not vaccinated, did source have contraindication to vaccination: ☐ **Y** (specify): ____________________ ☐ **N** ☐ **U**

PUBLIC HEALTH ACTIONS/NOTES

☐ Lost to follow-up