

Chickenpox Death

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control
 Infectious Disease Epidemiology Program
 Phone: 304-558-5358 or 800-423-1271 in West Virginia
 Fax: 304-558-8736

Investigation Information

* indicates required fields

Investigation Status*
 Closed Open Regional Review State Review Superseded Unassigned

Case Status*
 Confirmed Not a Case Probable Suspect Unknown

Patient Information

* indicates required fields

| | | |
|-------------------|--------------------|-----------------------|
| Last Name* | First Name* | Middle Initial |
|-------------------|--------------------|-----------------------|

Street Address

| | | | |
|-------------|---------------|-------------------------------|------------|
| City | County | State West Virginia | Zip |
|-------------|---------------|-------------------------------|------------|

Is the patient's residence a:
 Correctional Facility (Specify) _____ Long Term Care Facility (Specify) _____
 Shelter or Group Home (Specify) _____ None of the above

| | | | | |
|-----------------------------------|-------------|------------------------------------|-------------|----------------------------------|
| Home Phone ###-###-#### | Ext. | Other Phone ###-###-#### | Ext. | Report Date mm/dd/yyyy |
|-----------------------------------|-------------|------------------------------------|-------------|----------------------------------|

Parent / Guardian Information

| | | | |
|------------------|-------------------|-----------------------|--------------------------------|
| Last Name | First Name | Middle Initial | Relationship to Patient |
|------------------|-------------------|-----------------------|--------------------------------|

Check if address is same as above; otherwise complete guardian contact information below

Guardian Street Address

| | | | |
|-------------|---------------|-------------------------------|------------|
| City | County | State West Virginia | Zip |
|-------------|---------------|-------------------------------|------------|

| | | | |
|-----------------------------------|-------------|------------------------------------|-------------|
| Home Phone ###-###-#### | Ext. | Other Phone ###-###-#### | Ext. |
|-----------------------------------|-------------|------------------------------------|-------------|

Patient Demographic Information

* indicates required fields

Sex
 Male Female Transsexual Unknown Failure to report sex/missing sex Other (Specify) _____

| | | | |
|-------------------------------------|------------|---|------------------------------------|
| Date of Birth* mm/dd/yyyy | Age | Age Units <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years | Date of Death mm/dd/yyyy |
|-------------------------------------|------------|---|------------------------------------|

Patient Demographic Information cont.

Ethnicity
 Hispanic or Latino *Not Hispanic or Latino* *Unknown* *Failure to report ethnicity/missing ethnicity*

Race
 (Check all that apply)
 American Indian or Alaska Native *Asian*
 Black or African American *Native Hawaiian or Other Pacific Islander* _____
 White *Unknown*
 Failure to report race/missing race *Some Other Race* _____

Country of Birth **If Not Born in U.S., How Many Years Has Case Lived in U.S.?**

Clinical Information

Date of onset of symptoms
 mm/dd/yyyy **Date of diagnosis**
 mm/dd/yyyy

Was patient hospitalized for this disease? **Name of Hospital** **Date of Admission**
 Yes *No* *Unknown* mm/dd/yyyy

Rash Onset Date **Rash Type**
 mm/dd/yyyy *Generalized* *Localized/dermatomal* *Unknown*

Cause of Death Information
Discharge Summary Information Available **Varicella Included Among Diagnosis on Discharge Summary**
 Yes *No* *Unknown* *Yes* *No*

Discharge Diagnosis (Include ICD-10 Code if Available)

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

Post-Mortem Exam Done **Pathological Evidence of Varicella Noted**
 Yes *No* *Unknown* *Yes* *No*

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

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

Clinical Information cont.

Death Certificate Available
 Yes *No*
Varicella Included as One Cause of Death on Death Certificate
 Yes *No*
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 <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | If Yes, Age When Ill | Age Units <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |
| Pre-existing Condition? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | | |
| If Yes, Pre-existing Condition (Check All that Apply) <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer (Specify) _____ <input type="checkbox"/> Chronic Dermatologic Disorder (Specify) _____ <input type="checkbox"/> Chronic Lung Disease (Specify) _____ <input type="checkbox"/> Chronic Renal Failure <input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> HIV+/AIDS <input type="checkbox"/> Immune Deficiency (Type) <input type="checkbox"/> Pregnancy <input type="checkbox"/> Transplant Recipient (Organ) <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other Autoimmune Disease (e.g. Lupus, Rheumatoid Arthritis) (Specify) _____ <input type="checkbox"/> Other (Specify) _____ | | | |
| Did the Decedent Take Any Drugs Listed In This Section During The Month Prior to Rash Onset? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | | |
| If Yes, Check All That Apply <input type="checkbox"/> Steroids, Systemic <input type="checkbox"/> Steroids, Inhaled <input type="checkbox"/> Aspirin <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Immunosuppressants | | | |
| If Systemic Steroids Taken, Name | | If Systemic Steroids Taken, Dose mg/day | |
| Complications | | | |
| Secondary Infection <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | If Yes, Secondary Infection (Check all that apply) <input type="checkbox"/> Strep (Specify Below) <input type="checkbox"/> Staph <input type="checkbox"/> Mixed <input type="checkbox"/> Other (Specify) _____ | |
| If Strep From Above, Specify <input type="radio"/> Group A Beta-hemolytic <input type="radio"/> Other Type _____ <input type="radio"/> Unknown Type | | | |
| If Secondary Infection, Indicate Type (Check all that apply) <input type="checkbox"/> Abscess <input type="checkbox"/> Cellulitis <input type="checkbox"/> Impetigo/Infected Skin Lesions <input type="checkbox"/> Lymphadenitis <input type="checkbox"/> Necrotizing Fasciitis <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Sepsis/Septicemia <input type="checkbox"/> Septic Arthritis <input type="checkbox"/> Toxic Shock Syndrome <input type="checkbox"/> Other (Specify) _____ | | | |
| Other Complications (Check all that apply) <input type="checkbox"/> Congenital Varicella Syndrome <input type="checkbox"/> Pneumonia/Pneumonitis (Etiology, If Known): <input type="checkbox"/> Reye Syndrome <input type="checkbox"/> Other (Specify) _____ | | | |
| Neurologic Complications <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | If Neurologic Complications, What Type (Check all that apply) <input type="checkbox"/> Cerebellar Ataxia? <input type="checkbox"/> Encephalitis <input type="checkbox"/> Other (Specify) _____ | |

Complications cont.

Treatment-Medications

| Select Medication Taken | Medication | Dose | Date Started | Duration Days |
|-------------------------|----------------|--------|--------------|---------------|
| Y=Yes | | mg/day | mm/dd/yyyy | |
| | Acyclovir Oral | | | |
| | Acyclovir IV | | | |
| | Famciclovir | | | |
| | Valacyclovir | | | |

Select Other Medications Taken

Aspirin Non-Steroidal Anti-inflammatory Drugs (e.g. ibuprofen) Varicella Zoster Immune Globulin (VZIG)

If Varicella Zoster Immune Globulin, Date Administered

mm/dd/yyyy

Dose (U's)

Laboratory Information

Was Laboratory Testing for Varicella Done?

Yes No Unknown

Serology

IgM IgG Not Done Unknown

Serology Results

Positive Negative Indeterminate Pending Not Done Unknown

IgG Results

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

For Any Positive Test List Specimen and Date Collected

Rapid Diagnostic Test

Direct Fluorescent Antibody (DFA) Other (Specify) _____

| Specimen Number | Specimen | Date Collected |
|-----------------|----------|----------------|
| | | mm/dd/yyyy |
| 1st Specimen | | |
| 2nd Specimen | | |
| 3rd Specimen | | |

Viral Culture

| Specimen Number | Specimen | Date Collected |
|-----------------|----------|----------------|
| | | mm/dd/yyyy |
| 1st Specimen | | |
| 2nd Specimen | | |
| 3rd Specimen | | |

Laboratory Information cont.

Polymerase Chain Reaction (PCR)

| Specimen Number | Specimen | Date Collected | Strain Identified |
|-----------------|----------|----------------|-------------------|
| | | mm/dd/yyyy | W=Wild V=Vaccine |
| 1st Specimen | | | |
| 2nd Specimen | | | |
| 3rd Specimen | | | |

| | |
|---|--|
| Tzanck Smear Collection Date mm/dd/yyyy | Tzanck Smear Results <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown |
|---|--|

| | | | |
|------------------------|------------------------------|-------------|-----------------------------------|
| Laboratory Name | Phone ###-###-#### | Ext. | Fax Number ###-###-#### |
|------------------------|------------------------------|-------------|-----------------------------------|

Address

| | |
|--------------------------------|-------------|
| State: West Virginia | Zip: |
|--------------------------------|-------------|

Reporting Source

| | |
|------------------------------|----------------------------|
| Last Name | First Name |
| Phone ###-###-#### | Ext. |
| | Fax ###-###-#### |

Facility

Address

| | | |
|-------------|-------------------------------|------------|
| City | State West Virginia | Zip |
|-------------|-------------------------------|------------|

E-mail

Provider with Further Patient Information

| | |
|------------------------------|----------------------------|
| Last Name | First Name |
| Phone ###-###-#### | Ext. |
| | Fax ###-###-#### |

Address

| | | |
|-------------|-------------------------------|------------|
| City | State West Virginia | Zip |
|-------------|-------------------------------|------------|

Public Health Investigation

| | | |
|-----------------------------------|--------------------------------|---|
| Name of Person Interviewed | Relationship to Patient | Date reported to public health mm/dd/yyyy |
|-----------------------------------|--------------------------------|---|

Public Health Investigation cont.

| | | | |
|---------------------|---|--------------------------|------------------------------|
| Investigator | Date public health investigation began mm/dd/yyyy | Health Department | Phone ###-###-#### |
| Ext. | | | |

| | | | |
|-------------------------|---|----------------------|---|
| Investigation ID | Part of an Outbreak? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | Outbreak Name | Lost to follow-up? <input type="radio"/> Yes <input type="radio"/> No |
|-------------------------|---|----------------------|---|

Check if epi-linked to another case and complete information below

| | | |
|-------------------------------------|-------------------|--------------------------|
| Last Name of Epi-linked Case | First Name | DOB mm/dd/yyyy |
|-------------------------------------|-------------------|--------------------------|

| | |
|---------------|---------------------------------|
| County | Onset Date mm/dd/yyyy |
|---------------|---------------------------------|

Vaccine History

| | | |
|---|---------------------------------------|--|
| History of Previous Varicella? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | If Yes, Age When Had Varicella | Age Type <input type="radio"/> Days <input type="radio"/> Weeks <input type="radio"/> Months <input type="radio"/> Years |
|---|---------------------------------------|--|

| |
|---|
| Received Varicella Containing Vaccine? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
|---|

| Vaccination Date | Vaccine Type | Vaccine Manufacturer | Lot Number |
|------------------|---------------------------------|---------------------------|------------|
| mm/dd/yyyy | A=MMR B=Mumps O=Other U=Unknown | M=Merck O=Other U=Unknown | |
| | | | |
| | | | |
| | | | |

| | | |
|--|--|---|
| If Not Vaccinated, What Was The Reason? | | |
| <input type="radio"/> Religious exemption | <input type="radio"/> Medical Contraindication | <input type="radio"/> Philosophical exemption |
| <input type="radio"/> Lab evidence of previous disease | <input type="radio"/> MD diagnosis of previous disease | <input type="radio"/> Under age for vaccination |
| <input type="radio"/> Parental refusal | <input type="radio"/> Other _____ | <input type="radio"/> Unknown |

| |
|--|
| For Children <1 Year Old, Did Their Mother Have a History of Previous Varicella? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
|--|

| | | |
|--|--|--|
| Suspected Transmission Setting (Where did this case acquire varicella?) | | |
| <input type="radio"/> Daycare | <input type="radio"/> School | <input type="radio"/> Doctor's Office |
| <input type="radio"/> Work | <input type="radio"/> College | <input type="radio"/> Hospital (Ward/ER/Outpatient/Clinic) |
| <input type="radio"/> International Travel | <input type="radio"/> Other (specify): _____ | <input type="radio"/> Military |
| | | <input type="radio"/> Correctional Facility |
| | | <input type="radio"/> Home |
| | | <input type="radio"/> Church |
| | | <input type="radio"/> Unknown |

| |
|---|
| For Transmission Within the Home <input type="radio"/> Transmission From Family Member by Adoption <input type="radio"/> Transmission From Family Member Biologically Related |
|---|

| | |
|--|---|
| Source <input type="radio"/> Close Contact With a Person With Known or Suspected Infection, 10-21 Days Before Rash Onset <input type="radio"/> Unknown | Source Had <input type="radio"/> Shingles <input type="radio"/> Varicella <input type="radio"/> Unknown |
|--|---|

| | |
|---|--|
| Varicella Vaccine History of Source <input type="radio"/> Source Vaccinated <input type="radio"/> Source Not Vaccinated | If Not Vaccinated, Source Had Contraindication to Vaccination <input type="radio"/> Yes (Specify) _____ <input type="radio"/> No <input type="radio"/> Unknown |
|---|--|

Public Health Action Taken

Describe Public Health Action Taken