### DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>1. Date of Birth</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Current Age</td>
<td>Unknown (999)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Age Type</td>
<td>Years</td>
<td>Days</td>
<td>Weeks</td>
</tr>
<tr>
<td>4. Current Sex</td>
<td>Male</td>
<td>Female</td>
<td>Unknown</td>
</tr>
<tr>
<td>5. Ethnicity</td>
<td>American Indian or Alaska Native</td>
<td>Asian</td>
<td>Black or African-American</td>
</tr>
<tr>
<td>6. Race</td>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL HISTORY

<table>
<thead>
<tr>
<th>7. Date of Death</th>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Country of Birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If not born in the U.S., case lived in U.S. for</td>
<td>Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. History of varicella before this infection?</td>
<td>Y</td>
<td>N</td>
<td>U</td>
</tr>
<tr>
<td>12. If yes, age at infection?</td>
<td>Unknown (999)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Age Type</td>
<td>Years</td>
<td>Days</td>
<td>Weeks</td>
</tr>
<tr>
<td>15. Varicella Vaccine History</td>
<td>Vaccinated</td>
<td>Not Vaccinated</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Pre-existing conditions?**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>U</th>
</tr>
</thead>
</table>

**Cancer**

Type: 

**Transplant Recipient**

Organ: 

**Immune Deficiency**

Type: 

**Pregnancy**

**Chronic Renal Failure**

**Diabetes Mellitus**

**Tuberculosis**

**Asthma**

**Chronic Lung Disease**

Specify: 

**Chronic Dermatologic Disorder**

Specify: 

**Chronic Autoimmune Disease (e.g., Lupus, Reumatoid Arthritis)**

Specify: 

**Other**

Specify: 

20. For a child <1 year old, did his/her mother have a history of varicella? | Y | N | U |

21. For a child <1 year old, did his/her mother have a history of receipt of varicella vaccine? | Y | N | U |

22. Is this death the result of congenital varicella infection? | Y | N | U |

23. In the month prior to rash onset, did the decedent take any of the following? 

**Systemic Steroids**

Name of Steroid: 

Dose: mg/day

**Inhaled Steroids**

Name of Steroid: 

Dose: mg/day

**Other Systemic Medication**

List medication: 

1) 

2) 

3) 

4) 

...
ILLNESS PRIOR TO DEATH

Y=Yes  N=No  U=Unknown

24. Rash Onset Date

25. Was the rash generalized? □ Y □ N □ U

26. When first noted, did rash lesions seem to cluster on one side of the body?
   If “yes,” were lesions clustered on one limited area of the body involving no more than 3 dermatomes?
   If “yes,” which area? (check all that apply)
   □ Face/Head
   □ Arms
   □ Legs
   □ Trunk
   □ Inside Mouth
   □ Other (Specify)

27. Was the case hospitalized? □ Y □ N □ U
   Admission Date

   If obtainable, please attach a copy of the hospital discharge summary.

COMPLICATIONS (check all that apply)

28. □ Secondary Infection
   From □ Strep
   □ Group A beta-hemolytic
   □ Other type
   □ Unknown type
   □ Staph
   □ MRSA
   □ Other (Specify) ____________________________
   □ Mixed
   □ Other (Specify) ____________________________

   Type of Infection
   □ Cellulitis
   □ Osteomyelitis
   □ Impetigo/Infected Skin Lesions
   □ Necrotizing Fasciitis
   □ Lymphadenitis
   □ Toxic Shock Syndrome
   □ Abscess
   □ Sepsis/Septicemia
   □ Septic Arthritis
   □ Other (Specify) ____________________________

29. □ Pneumonia/Pneumonitis
   Etiology, if known ____________________________

30. □ Neurologic Complications
   □ Cerebellitis/Ataxia
   □ Encephalitis
   □ Other (Specify) ____________________________

31. □ Reye’s Syndrome

32. □ Other (Specify) ____________________________

TREATMENT – MEDICATIONS (check all that apply)

33. □ Acyclovir
   □ Oral Dose □□□□ mg/day
   Start Date □□ □□ □□□□ MONTH DAY YEAR
   Duration □□□ days

   □ IV Dose □□□□ mg/day
   Start Date □□ □□ □□□□ MONTH DAY YEAR
   Duration □□□ days

34. □ Famiclovir
   Dose □□□□ mg/day
   Start Date □□ □□ □□□□ MONTH DAY YEAR
   Duration □□□ days

35. □ Valacyclovir
   Dose □□□□ mg/day
   Start Date □□ □□ □□□□ MONTH DAY YEAR
   Duration □□□ days

36. □ Varicella Zoster Immune Globulin (VZIG)
   Dose □□□□ U's
   Date Admin'd □□ □□ □□□□ MONTH DAY YEAR

37. □ Aspirin

38. □ Non-Steroidal Anti-Inflammatory Drugs (i.e., ibuprofen)

continues
39. **Was laboratory testing done for varicella**? If “yes”:

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>U</th>
</tr>
</thead>
</table>

40. **Direct fluorescent antibody (DFA) technique?**

<table>
<thead>
<tr>
<th>Date of DFA</th>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**DFA Result**

- Positive
- Negative
- Not Done
- Indeterminate
- Unknown

41. **PCR specimen?**

<table>
<thead>
<tr>
<th>Date of PCR Specimen</th>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**Source of PCR specimen:** (check all that apply)

- Vesicular Swab
- Saliva
- Scab
- Blood
- Tissue Culture
- Urine
- Buccal Swab
- Macular Scraping
- Other

**PCR Result**

- Varicella Positive
- Not Done
- Varicella Negative
- Pending
- Indeterminate
- Unknown
- Other

**Was the PCR specimen adequate (i.e., was it actin positive)?**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>U</th>
</tr>
</thead>
</table>

42. **Culture performed?**

<table>
<thead>
<tr>
<th>Date of Culture Specimen</th>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**Culture Result**

- Positive
- Negative
- Not Done
- Indeterminate
- Unknown

43. **Was other laboratory testing done?** If “yes”:

**Specify Other Test**

- Tzanck smear
- Electron microscopy

**Date of Other Test**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**Other Lab Test Result**

- Positive (results consistent with varicella infection)
- Negative
- Indeterminate
- Not Done
- Pending
- Unknown

**Test Result Value**

44. **Serology performed?**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>U</th>
</tr>
</thead>
</table>

45. **IgM performed?** If “yes”:

**Type of IgM Test**

- Capture ELISA (specify manufacturer):
- Indirect ELISA (specify manufacturer):
- Other

**Date IgM Specimen Taken**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**IgM Test Result**

- Positive
- Negative
- Not Done
- Indeterminate
- Unknown

**Test Result Value**

46. **IgG performed?** If “yes”:

**Type of IgG Test**

- Whole Cell ELISA (specify manufacturer):
- gp ELISA (specify manufacturer):
- FAMA
- Latex Bead Agglutination
- Other

**Date of IgG-Acute**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**IgG-Acute Result**

- Positive
- Negative
- Not Done
- Indeterminate
- Unknown

**Test Result Value**

47. **Were the clinical specimens sent to CDC for genotyping (molecular typing)?** If “yes”:

**Date sent for genotyping**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

48. **Was specimen sent for strain (wild- or vaccine-type) identification?**

**Strain Type**

- Wild Type Strain
- Vaccine Type Strain
- Unknown

49. **Any herpes simplex virus testing performed?** If “yes”:

**Type of Test**

**Date of Other Test**

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**Test Result**

- Positive
- Negative
- Not Done
- Indeterminate

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**It can be difficult to distinguish varicella from disseminated herpes zoster (shingles). Serum or blood obtained from the decedent prior to or early in illness (i.e., weeks before to ~4 days after rash onset) could be used to test for evidence of prior varicella infection, which could sometimes help distinguish these two conditions. If there is doubt whether the cause of death was related to varicella or to disseminated herpes zoster, an effort should be made as soon as possible to determine whether any such blood or serum specimens may be available. For instance, serum specimens at hospital laboratories or a blood banks may be retained for many weeks.**

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**continues**
50. Discharge summary information available? □ Y □ N □ U

51. Varicella included among diagnoses? □ Y □ N □ U

52. Discharge Diagnoses
   a. ___________________________ ICD-9 Code □□□□□□
   b. ___________________________ ICD-9 Code □□□□□□
   c. ___________________________ ICD-9 Code □□□□□□

53. Post-mortem exam done? □ Y □ N □ U

54. Varicella included among diagnoses? □ Y □ N □ U

55. If evidence of varicella, significant findings related to varicella-zoster virus infection, by organ system:
   a. Organ 
      Findings
   b. Organ 
      Findings
   c. Organ 
      Findings
   d. Organ 
      Findings
   e. Organ 
      Findings
   f. Other 

56. Death certificate available? □ Y □ N □ U

57. Varicella included as one cause of death? □ Y □ N □ U

58. Cause of Death
   a. ___________________________ ICD-9 Code □□□□□□
   b. ___________________________ ICD-9 Code □□□□□□
   c. ___________________________ ICD-9 Code □□□□□□
   d. ___________________________ ICD-9 Code □□□□□□

59. Case had close contact with a person with known or suspected infection 10-21 days before rash onset? □ Y □ N □ U

60. Source had □ Shingles □ Varicella □ Unknown

61. Current Age □□□□□□ (Unknown=999)

62. Age Type □ Years □ Days □ Hours 
   □ Months □ Weeks □ Unknown

63. Varicella vaccine history of source □ Source vaccinated 
   □ Source not vaccinated □ Y □ N □ U

64. If not vaccinated, source had contraindication to vaccination?
   If yes, specify ___________________________

65. Transmission Setting (Setting of Exposure)
   □ Athletics □ College □ Hospital Outpatient Clinic 
   □ Community □ Correctional Facility □ Hospital Ward 
   □ Daycare □ Doctor's Office □ International Travel 
   □ Home □ Military □ Place of Worship 
   □ Hospital ER □ School □ Work 
   □ Other □ Unknown

66. If transmission was in the home □ Transmission from family member by adoption 
   □ Transmission from family member biologically related 

67. Any international travel in the 4 weeks prior to illness? □ Y □ N □ U
   If yes, what dates? ___________________________
   What country(ies)? ___________________________