



Varicella Death

County _____

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ Years Months

Alternate name _____

Phone _____ Email _____

Address type Home Mailing Other Temporary Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHM Case ID (optional) _____

LHM notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHM _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (*specify:* Amer Ind *and/or* AK Native) Asian Black or African American

Native HI/Pacific Islander (*specify:* Native HI *and/or* Pacific Islander) White Patient declined to respond Unk

Additional race information:

Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese

Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian

Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong

Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen

Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo

Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo

Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali

South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian

Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese

Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese

Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco

Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan

Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya

Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____
 Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years

Clinical Features and Complications**Y N Unk**

Acute illness with diffuse (generalized) vesiculopapular rash
 Number of lesions <50 50-249 250-499 ≥500 Unk
 Encephalitis
 Pneumonia
 Diagnosed by X-Ray CT MRI Provider Only
 Result Positive Negative Indeterminate Not tested Other _____
 Disseminated systemic varicella
 Any other complication _____

Vaccination**Y N Unk**

Ever received a varicella containing vaccine Number of varicella doses prior to illness _____

Vaccine information available Yes No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____
 Vaccine lot number _____ Administering provider _____
 Information source Washington Immunization Information System (WIIS) WIIS ID number _____
 Medical record Patient vaccination card Verbal only/no documentation Other state IIS
 Date of vaccine administration ___/___/___ Vaccine administered (Type) _____
 Vaccine lot number _____ Administering provider _____
 Information source Washington Immunization Information System (WIIS) WIIS ID number _____
 Medical record Patient vaccination card Verbal only/no documentation Other state IIS

Y N Unk

Varicella vaccination up to date for age per ACIP
 Vaccine series not up to date reason
 Religious exemption Medical contraindication Philosophical exemption
 Laboratory confirmation of previous disease MD diagnosis of previous disease
 Underage for vaccine Parental refusal Other Unknown

Hospitalization**Y N Unk**

Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___
 Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
 Mechanical ventilation or intubation required

Y N Unk

Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
 Death certificate lists disease as a cause of death or a significant contributing condition
 Autopsy performed
 Location of death Outside of hospital (e.g., home or in transit to the hospital)
 Emergency department (ED) Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures 10-21 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	____/____/____ to ____/____/____	____/____/____ to ____/____/____	____/____/____ to ____/____/____

Risk and Exposure Information

Y N Unk

Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____

Exposure and Transmission Summary

Y N Unk

Epi-linked to another person with a vesiculopapular rash
 Outbreak or cluster related death

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Person to person Health care associated Unk
 Other _____
 Describe _____

Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____
 Describe _____

Exposure summary

Suspected transmission type (check all that apply) Person to person Health care associated Unk
 Other _____
 Describe _____

Suspected transmission setting (check all that apply) Day care/Childcare School (not college) Doctor's office
 Hospital ward Hospital ER Hospital outpatient facility Home Work College Military
 Correctional facility Place of worship Laboratory Long term care facility Homeless/shelter
 International travel Out of state travel Transit Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____
 Describe _____

Public Health Interventions/Actions

Y N Unk

Exclude exposed susceptibles from work/school for incubation period
 Letter sent Date ____/____/____ Batch date ____/____/____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Day care School Airport Hotel/Motel/Hostel Transit Health care Home Work College
 Military Correctional facility Place of worship International travel Out of state travel LTCF
 Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	__/__/__	__/__/__	__/__/__	__/__/__
End Date	__/__/__	__/__/__	__/__/__	__/__/__
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

TREATMENT

Y N Unk

Did patient receive prophylaxis/treatment

Specify medication Antibiotic Fungal/Parasitic Antiviral Immune globulin/Antitoxin
 Other _____

Indication PEP Treatment for disease Incidental Other _____

Did patient take medication as prescribed Yes No - Why not _____ Unk

Prescribing provider _____

NOTES

LAB RESULTS

Lab report information

Lab report reviewed – LHJ

WDRS user-entered lab report note

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen

Specimen identifier/accession number _____

Specimen collection date __/__/__ **Specimen received date** __/__/__

WDRS specimen type _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result

WDRS test performed _____

WDRS test result, coded _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

Case Name _____

LHJ Case ID _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed Pending
Test result status Final results; Can only be changed with a corrected result
 Preliminary results
 Record coming over is a correction and thus replaces a final result
 Results cannot be obtained for this observation
 Specimen in lab; results pending

Result date ___/___/___

Upload document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

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