



Varicella Death

County _____

Case name (last, first) _____
 Birth date ___/___/___ Sex at birth F M Other 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 _____
 LHJ Case ID (optional) _____
 LHJ notification date ___/___/___
Classification Classification pending Confirmed
 Not reportable Probable Ruled out Suspect
 Investigation status
 In progress
 Complete
 Complete – not reportable to DOH
 Unable to complete Reason _____
 Investigation start date ___/___/___
 Investigation complete date ___/___/___
 Case complete date ___/___/___
 Outbreak related Yes No
 LHJ Cluster ID _____ Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ Years Months
Ethnicity Hispanic or Latino Not Hispanic or Latino Unk
Race (check all that apply) Unk Amer Ind/AK Native
 Asian Black/African Amer Native HI/other PI
 White Other _____
 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 _____

REPORT SOURCE

Initial report source _____
 LHJ _____
 Reporter organization _____
 Reporter name _____
 Reporter phone _____
 All reporting sources (list all that apply)

Primary HCP name _____
 Phone _____
 Alternate contact Parent/Guardian Spouse/Partner
 Friend Other _____
 Contact name _____
 Contact phone _____

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 RESULTSLab 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 _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed PendingTest 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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____