



# 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 \_\_\_\_\_  
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 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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