State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Immunization Branch
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VARICELLA HOSPITALIZATION or DEATH CASE REPORT FORM

PATIENT DEMOGRAPHICS

Last Name	First Name	Middle Name	Suffix

Social Security Number (9 digits)	DOB (mm/dd/yyyy)	Age	
			☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	Apartment / Unit Number

City / Town	State	Zip Code

Census Tract	County of Residence	Country of Residence

Country of Birth	If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)

Home Telephone	Cellular Phone / Pager	Work / School Telephone

E-mail Address	Other Electronic Contact Information

Work / School Location	Work / School Contact

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	If Yes, Est. Delivery Date (mm/dd/yyyy)

Medical Record Number	Patient's Parent/Guardian Name

Occupation Setting	Other Describe/Specify

Occupation	Other Describe/Specify

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 8)
The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.
☐ American Indian or Alaska Native
☐ Asian (check all that apply, see list on page 8)
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
(check all that apply, see list on page 8)
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ Other: _____

☐ White
☐ Other: _____
☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

SIGNS AND SYMPTOMS			
Vesicular Rash ☐ Yes ☐ No ☐ Unknown	Rash Onset Date (mm/dd/yyyy)	Generalized Rash ☐ Yes ☐ No ☐ Unknown	Duration of Rash
Severity of Rash ☐ Mild (<50 lesions) ☐ Mild / Moderate (50 – 249 lesions) ☐ Moderate (250 – 499 lesions) ☐ Severe (500 or more lesions) ☐ Unknown	Direction of Spread:		
Fever ☐ Yes ☐ No ☐ Unknown			
Other Symptoms ☐ Yes ☐ No ☐ Unknown	If yes, describe:		

HOSPITALIZATION			
Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unknown	Hospitalized? ☐ Yes ☐ No ☐ Unknown	Days Hospitalized	
ICU Admission ☐ Yes ☐ No ☐ Unknown			
Hospital Name	Street Address		
City	State	ZIP Code	Telephone
Admit Date (mm/dd/yyyy)		Discharge / Transfer Date (mm/dd/yyyy)	
Medical Record Number	Discharge Diagnosis		

HOSPITALIZATION – VARICELLA INFORMATION
Primary reason for hospitalization (check all that apply) ☐ Severe varicella presentation ☐ Varicella-related complication ☐ Observation ☐ Administration of IV Treatment ☐ Non-varicella hospitalization with coincident varicella ☐ Isolation ☐ Unknown ☐ Other (specify):

COMPLICATIONS AND OTHER SYMPTOMS

Did the patient develop any complications during hospitalization?

☐ Yes ☐ No ☐ Unknown

Dehydration / Hypovolemia ☐ Yes ☐ No ☐ Unknown	Meningitis ☐ Yes ☐ No ☐ Unknown	Pneumonia ☐ Yes ☐ No ☐ Unknown	Encephalitis ☐ Yes ☐ No ☐ Unknown
Skin / soft tissue infection ☐ Yes ☐ No ☐ Unknown	Cerebellar ataxia ☐ Yes ☐ No ☐ Unknown	Hemorrhagic condition ☐ Yes ☐ No ☐ Unknown	
Other Complications ☐ Yes ☐ No ☐ Unknown	Describe other complications:		

Did patient die?

☐ Yes ☐ No ☐ Unknown

VACCINATION HISTORY

Has the patient been immunized for this disease? ☐ Yes ☐ No ☐ Unknown	Type of vaccine administered for last dose ☐ Monovalent Varicella Vaccine ☐ MMRV

Number of doses prior to onset of illness?

Dose #1 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
Dose #2 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
Dose #3 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)
Dose #4 ☐ Yes, documented ☐ Yes, alleged	Date (mm/dd/yyyy)

Reason Not Vaccinated

☐ Personal Beliefs Exemption (PBE) ☐ Permanent Medical Exemption (PME) ☐ Temporary Medical Exemption ☐ Lab confirmation of previous disease
☐ MD diagnosis of previous disease ☐ Under age for vaccination ☐ Delay in starting series or between doses ☐ Unknown ☐ Other

If Other, Specify

MEDICAL HISTORY

Immunocompromised ☐ Yes ☐ No ☐ Unknown	Reason that the patient is immunocompromised (list any immunocompromising medications or conditions, separated by semi-colon, except those that may disclose HIV/AIDS status.):

Prior MD diagnosis of this disease? Any pre-existing conditions?

☐ Yes ☐ No ☐ Unknown

Describe any pre-existing conditions

TREATMENT
Was the patient treated with antivirals for this condition? ☐ Yes ☐ No ☐ Unknown
Specify type of antiviral treatment received:

LABORATORY RESULTS – DETAILS	
Test type ☐ DFA ☐ PCR ☐ Virus Isolation ☐ IgM ☐ IgG ☐ Other ☐ Unknown	If Other, specify:
Specimen Source	If Other, specify:
Date specimen collected (mm/dd/yyyy)	Result
Laboratory Name	Telephone

LABORATORY RESULTS – DETAILS	
Test type ☐ DFA ☐ PCR ☐ Virus Isolation ☐ Other	If Other, specify:
Specimen Source	If Other, specify:
Date specimen collected (mm/dd/yyyy)	Result
Laboratory Name	Telephone

ADDITIONAL LABORATORY RESULTS	
Case Lab Confirmed ☐ Yes ☐ No ☐ Unknown	
If virus was isolated and sent for further testing at CDC, complete the following questions	
Date sent for genotyping (mm/dd/yyyy)	Virus Genotype
Date sent for strain typing (mm/dd/yyyy)	Strain Type ☐ Wild-type ☐ Vaccine-type

INCUBATION PERIOD

INCUBATION PERIOD IS 21 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

Did patient travel or have visitors during the incubation period? ☐ Yes ☐ No ☐ Unknown	Close contact with person(s) with rash during the incubation period? ☐ Yes ☐ No ☐ Unknown
Acquisition Setting:	Close contact with person(s) with shingles (zoster) during the incubation period? ☐ Yes ☐ No ☐ Unknown
Travel Type ☐ Domestic ☐ International	
State	Country
Location Details	
Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
Did patient fly while infectious? ☐ Yes ☐ No ☐ Unknown	
Airline	Flight Number
Departure Date (mm/dd/yyyy)	Arrival Date (mm/dd/yyyy)

SPREAD SETTING

Setting Type:	Name of Setting:
First Date of Contact (mm/dd/yyyy)	Last Date of Contact (mm/dd/yyyy)
Number Exposed	Notes

GENERAL CONTACTS

Number of susceptible contacts
Close contacts with rash 8-17 days after exposure to case? ☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGICAL LINKAGE

Was this case epi-linked to a known case? ☐ Yes ☐ No ☐ Unknown
Part of known outbreak? ☐ Yes ☐ No ☐ Unknown

STATE REPORTING REQUIREMENTS

Reportable

- Persons who were hospitalized or who died due to primary varicella (chickenpox) infection (create a 'Varicella Hospitalization/Death' incident in CalREDIE).
- Varicella outbreaks (≥3 cases) (create a 'Varicella (Chickenpox)' incident in CalREDIE for each case in the outbreak and create a 'Rash' outbreak incident in CalREDIE).

Non-reportable

- Single, non-hospitalized varicella cases Herpes zoster (shingles) cases

CLINICAL CASE DEFINITION (2023)

In the absence of a more likely diagnosis:

- An acute illness with a generalized rash with vesicles (maculopapulovesicular rash), OR
- An acute illness with a generalized rash without vesicles (maculopapular rash).

In vaccinated persons who develop "breakthrough" varicella more than 42 days after vaccination, the disease is almost always mild with fewer than 50 skin lesions and shorter duration of illness. The rash may also be atypical in appearance (maculopapular with few or no vesicles).

LABORATORY CRITERIA FOR DIAGNOSIS

Confirmatory:

- Positive polymerase chain reaction (PCR) for varicella-zoster virus (VZV) DNA, OR
- Positive direct fluorescent antibody (DFA) for VZV DNA, OR
- Isolation of VZV, OR
- Significant rise (i.e., at least a 4-fold rise or seroconversion) in VZV IgG antibody.

Supportive: Positive test for serum VZV immunoglobulin M (IgM) antibody.

Laboratory notes:

- *PCR of scabs or vesicular fluid is the preferred method for laboratory confirmation of varicella. In* the absence of *vesicles or scabs, scrapings of maculopapular lesions can be collected for testing.*
- *Seroconversion is defined as a negative serum VZV IgG followed by a positive serum VZV IgG. In vaccinated persons, a 4-fold rise may not occur.*
- *IgM serology has limited value as a diagnostic method for VZV infection and is not recommended for* laboratory confirmation *of varicella. However, an IgM positive result in the presence of varicella-like symptoms can indicate a likely acute VZV infection. A positive IgM result in the absence of clinical disease is not considered indicative of active varicella*.

Healthcare record evidence

- Provider diagnosis of varicella or chickenpox but no rash description.

CASE CLASSIFICATION
Confirmed:

- Meets clinical evidence AND confirmatory laboratory evidence, OR
- Meets clinical evidence with a generalized rash with vesicles AND confirmatory epidemiologic linkage evidence

Probable:

- Meets clinical evidence with a generalized rash with vesicles, OR
- Meets clinical evidence with a generalized rash without vesicles AND:
    - epidemiologic linkage evidence, OR
    - supportive laboratory evidence, OR
- Meets healthcare record criteria AND:
    - confirmatory or presumptive epidemiologic linkage evidence, OR
    - confirmatory or supportive laboratory evidence.

Epidemiologic linkage evidence

Confirmatory:

- Exposure to or contact with a laboratory-confirmed varicella case, OR
- Can be linked to a varicella cluster or outbreak containing ≥1 laboratory-confirmed case, OR
- Exposure to or contact with a person with herpes zoster (regardless of laboratory confirmation).

Presumptive: Exposure to or contact with a probable varicella case that had a generalized rash with vesicles.

VARICELLA DEATH CLASSIFICATIONS (CDPH)

Confirmed: A death resulting from a confirmed case of varicella which contributes directly or indirectly to acute medical complications that result in death.
Probable: A death resulting from a probable case of varicella which contributes directly or indirectly to acute medical complications that result in death.

Investigator Name (print)	Telephone Number
Agency Name	
Date (mm/dd/yyyy)	

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

Bangladeshi	Filipino	Japanese	Maldivian	Sri Lankan
Bhutanese	Hmong	Korean	Nepalese	Taiwanese
Burmese	Indian	Laotian	Okinawan	Thai
Cambodian	Indonesian	Madagascar	Pakistani	Vietnamese
Chinese	Iwo Jiman	Malaysian	Singaporean	

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

Carolinian	Kiribati	Micronesian	Pohnpeain	Tahitian
Chamorro	Kosraean	Native Hawaiian	Polynesian	Tokelauan
Chuukese	Mariana Islander	New Hebrides	Saipanese	Tongan
Fijian	Marshallese	Palauan	Samoan	Yapese
Guamanian	Melanesian	Papua New Guinean	Solomon Islander	