

## Instructions for Varicella Death Investigation Worksheet

The following information is being collected to understand more about varicella-related deaths. Certain information, such as pre-existing conditions, may indicate whether certain persons are at an increased risk for developing severe varicella. While "unknown" is an option for many questions, please make every effort to obtain the appropriate information before checking this box.

*Please complete and send to California State Immunization Branch at 850 Marina Bay Parkway, Building P, 2<sup>nd</sup> Floor, Richmond, CA 94804.*

### **Demographic Data:**

**Date of Birth:** If known, enter the birth date; August 9, 1957 would be entered 08/09/57. If unknown, leave blank and enter the age and agetype.

**Age and Age Type:** Age of decedent in number of years, months, weeks, or days as indicated by the age type codes.

**Date of Death:** Indicate date of death in the same format as date of birth. Country of Origin: Indicate the country where the decedent was born.

**If Not Born in U.S., Case has lived in U.S. For \_\_ Years:** If not born in the U.S., indicate for how many years the decedent has lived in the U.S.

**Occupation:** If the decedent's occupation is not specified, enter "0" for other and document the occupation, if known (it is a priority to vaccinate individuals in the occupational categories indicated).

### **Past Medical History:**

**History of Previous Varicella:** Enter the appropriate code to indicate whether the decedent had varicella *prior to the current varicella illness*.

**If Yes, Age When Ill:** If decedent had varicella prior to the current illness, indicate age in number of years, months, weeks or days as indicated by age type codes.

**Varicella Vaccine History:** Indicate whether the decedent received varicella vaccine. Especially for persons of international origin, clarify varicella vaccine versus small pox vaccine.

**If Ever Vaccinated:** Enter the date(s) in the format indicated above for date of birth.

**Contraindication to Vaccination?** Indicate if the decedent had a contraindication that prevented varicella vaccination. If yes, specify the contraindication in the space provided. Include all contraindications whether they are considered valid or not. Contraindications may include: allergy to a component of the vaccine (neomycin or gelatin) or history of a severe allergic reaction to a prior dose of the vaccine; persons with immunodeficiency, including cancers, leukemias, congenital immunodeficiencies, infection with HIV, or persons taking large doses of corticosteroids (>2 mg/kg of body weight or >20 mg/day of prednisone or its equivalent); decedent's mother was pregnant at the time of vaccination; decedent too old or decedent ill at time of vaccination as well as others not stated here.

**Pre-existing Conditions:** Indicate whether the decedent had any of the pre-existing conditions listed in this section. If yes, check all of the pre-existing conditions that apply.

**Drugs Taken During the Month Prior to Rash Onset:** Indicate whether the decedent had taken any of the drugs listed in this section within one month prior to rash onset. If yes, then check all drugs that apply.

### **Illness Prior to Death:**

**Rash Onset:** Indicate the date the decedent's rash was first noted.

**Hospitalized:** Indicate whether or not the decedent was hospitalized as a result of varicella illness or its complications. This does *not* exclude hospitalization for a pre-existing condition when varicella resulted in a prolonged hospital stay.

**Complications:** Indicate any complications that the decedent experienced as a result of varicella illness by checking the appropriate

boxes in this section.

**Pneumonia/Pneumonitis:** Include both confirmed or suspected viral or bacterial pneumonia/pneumonitis. List specific etiologic organism, if known.

**Treatment--Medications:** Check off any medications that the decedent received as treatment for varicella. If indicated, fill in the dose, the date the drug was started, and for how many days it was continued.

**Laboratory Data:**

**Varicella Laboratory Testing:** Enter the appropriate code to indicate whether any varicella-specific laboratory testing was done. If yes, indicate the type(s), dates, specimen (e.g. vesicular fluid, CSF, scraping from base of skin lesion), and titers of any positive test.

**Hospital Discharge Summary Data\*:**

**Discharge Summary Information Available?** If actual summary is not available, contact the Infection Control Practitioner (or other professional) to obtain summary information.

**Discharge Diagnoses:** Write the discharge diagnoses listed on the discharge summary and, if available, include the ICD-9 codes.

\*If available, please attach a copy of the hospital discharge summary. Make a photocopy, remove all personal identifiers and clearly write the case number on the summary before sending.

**Post-Mortem Examination Data:**

**If Yes, Indicate Significant Findings Related to Varicella-zoster Virus Infection, by Organ System:** If findings on the post-mortem examination are related to varicella-zoster virus infection or its complications, indicate the organ and the findings noted.

**Death Certificate Data:**

**Part I: Cause of Death:** list the cause of death and ICD-9 codes indicated on the death certificate.

**Part II: Contributing conditions:** list the contributing conditions and ICD-9 codes indicated on the death certificate.

**Source Data:**

**Source:** The source is the person from whom the decedent contracted varicella. If known, indicate whether the decedent was exposed to varicella-zoster virus by close contact with an infected individual (i.e. the source), 10-21 days prior to rash onset

**Source Had:** Indicate whether the source had shingles, varicella, or if this was unknown.

**Varicella Vaccine History:** Indicate whether the source had ever received a vaccination.

**If Not Vaccinated, Source Had Contraindications to Vaccination?** If not vaccinated, indicate whether the source had a contraindication to vaccination (contraindications listed above in "Past Medical History" section).

**Suspected Transmission Setting:** Indicate the setting in which the decedent was exposed to the source.

**For transmission within the home:** If transmission occurred in the home setting, indicate whether the source was a family member by adoption or a biologically related family member of the decedent. *This question is intended to address the issue of whether secondary cases of varicella are more severe in genetically similar individuals. The varicella zoster virus is an enveloped virus that may have the ability to "hide" more effectively in HLA similar persons, and the immune response may be correspondingly lower (correlating with increased disease severity).*