

Patient Information

Name (Last, First): _____
 Date of Birth: ____ / ____ / ____ or Age (yrs): ____
 Sex: Male Female
 Address: _____
 City/State/Zip: _____
 Phone: _____

Provider Information (Results will be sent to provider)

Name: _____
 Institution: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____ Fax: _____
 Email: _____

Specimen Information

Date Collected: ____ / ____ / ____
Source of Specimen (check for each specimen):

Specimen 1:	Specimen 2:
<input type="checkbox"/> Vesicle (fluid-filled blister)	<input type="checkbox"/> Vesicle (fluid-filled blister)
<input type="checkbox"/> Macule/Papule (red, raised lesion)	<input type="checkbox"/> Macule/Papule (red, raised lesion)
<input type="checkbox"/> Crust/Scab	<input type="checkbox"/> Crust/Scab
<input type="checkbox"/> Other Skin Specimen	<input type="checkbox"/> Other Skin Specimen
<input type="checkbox"/> Blood	<input type="checkbox"/> Blood
<input type="checkbox"/> Cerebrospinal Fluid	<input type="checkbox"/> Cerebrospinal Fluid
<input type="checkbox"/> Other (specify below): _____	<input type="checkbox"/> Other (specify below): _____

If there are additional specimens, please indicate source of each specimen on next page.*

Reason for Specimen Submission:

Suspected vaccine adverse event (including verification of vaccine strain or transmission of vaccine virus)

Lab confirmation of varicella or zoster diagnosis

Determine patient's susceptibility

Other (specify below): _____

If an adverse event is suspected, has a VAERS report been submitted?

Yes - VAERS number: _____ No

In the week prior to specimen collection, did the patient take oral antivirals (i.e., acyclovir, famciclovir, or valacyclovir)?

Yes No Unknown

Clinical History

Date of Rash Onset: ____ / ____ / ____

Rash Type (check all that apply):

Vesicles (fluid) Macule/Papule (red, raised lesion)

Other (describe): _____

Total # Lesions: <50 50-249 250-500 >500 Unknown

Clinical Diagnosis:

Varicella (Chickenpox)

Zoster (Shingles) Body site/Dermatome: _____

Other (specify): _____

Unknown

Conditions/Medications/Treatment:

Does the patient have any current chronic medical condition that depresses the immune system (e.g., cancer, leukemia, HIV/AIDS, organ transplant)?

Yes No Unknown

If yes, specify: _____

Did the patient take **steroid(s)** (i.e., oral $\geq 2\text{mg/kg}$ of body weight or total of $\geq 20\text{mg/day}$ of prednisone or equivalent for persons $> 10\text{kg}$ and administered for ≥ 2 weeks) or **immunosuppressant(s)** during the month prior to rash onset?

Yes No Unknown

Was the patient prescribed **antivirals** (i.e., oral acyclovir, famciclovir, or valacyclovir) to treat this rash?

Yes No Unknown

If yes, dates of treatment: _____

VZV Vaccine Information

Has the patient received varicella-containing vaccine?

Yes No Unknown

Dose 1: Date: ____ / ____ / ____ Lot #: _____
 Vaccine Type: Varivax MMRV Zostavax

Dose 2: Date: ____ / ____ / ____ Lot #: _____
 Vaccine Type: Varivax MMRV Zostavax

Note: Please contact Scott Grytdal at CDC before sending specimens. Tel: 404-639-1483.

* See Page 2 for additional specimen handling instructions and provide additional information.

Additional Clinical or Laboratory Testing Information:

Additional Clinical Information: _____

Please specify any other lab work performed: _____

Additional Specimen Information:

Source of Specimen (check for each specimen):

Specimen 3:

- Vesicle (fluid-filled blister)
- Macule/Papule (red, raised lesion)
- Crust/Scab
- Other Skin Specimen
- Blood
- Cerebrospinal Fluid
- Other (specify below):

Specimen 5:

- Vesicle (fluid-filled blister)
- Macule/Papule (red, raised lesion)
- Crust/Scab
- Other Skin Specimen
- Blood
- Cerebrospinal Fluid
- Other (specify below):

Specimen 4:

- Vesicle (fluid-filled blister)
- Macule/Papule (red, raised lesion)
- Crust/Scab
- Other Skin Specimen
- Blood
- Cerebrospinal Fluid
- Other (specify below):

Specimen 6:

- Vesicle (fluid-filled blister)
- Macule/Papule (red, raised lesion)
- Crust/Scab
- Other Skin Specimen
- Blood
- Cerebrospinal Fluid
- Other (specify below):

MAIL FORM AND SPECIMEN TO:

CDC • National VZV Laboratory • 1600 Clifton Rd, NE • MS G-18 • Atlanta, GA 30333
Tel: (404)639-3667 • Fax: (404)639-4056 • E-mail: vzvlab@cdc.gov

Additional Instructions:

1. Information on specimen collection, shipment, and handling can be found online at:
<http://www.cdc.gov/vaccines/vpd-vac/varicella/surv-collect-virus-spec.htm>.
2. Label each specimen with specimen number (corresponding to information provided on this form i.e., "Specimen 1") and the source of the specimen (e.g., vesicle, maculepapule, etc.)
3. Place each specimen collected from different lesions in a separate labeled tube or container.
4. Please indicate if you have already notified your state or local health department about this case:
 Yes No