VZV Specimen Collection Form

CDC Centers for Disease Control and Prevention

Department of Health & Human Services - USA

Unique Identifier Assigned by CDC

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:

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

_____

Specimen 2:

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

History of Chickenpox/Shingles:

☐ Yes chickenpox - Age: _____ ☐ No chickenpox ☐ Unknown

☐ Yes shingles - Age: _____ ☐ No shingles ☐ 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 ≥2mg/kg of body weight or total of ≥20mg/day of prednisone or equivalent for persons >10kg and administered for ≥2 weeks) or **immunosupressant(s)** during the month prior to rash onset?

☐ Yes ☐ No ☐ Unknown

Was the patient prescribed **antivirals** (i.e., oral acyclovir, famiciclovir, or valavyclovir) 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: Contact CDC before sending specimens at 404-639-0066 or 404-639-3667.

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

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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 4:
- ☐ 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 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

Additonal Instructions:

1. Information on specimen collection, shipment, and handling can be found online at:
   http://www.cdc.gov/shingles/lab-testing/index.html
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