CRF - Varicella-Zoster Virus (VZV) associated hospitalisations (incl. post infectious complications)

1. Basic data

Reporting hospital	______________________________	
Reporting physician	______________________________	
Month/Year of birth	____________________ (mm/yyyy)	
Gender	male female	
Resident in CH	yes no	If no, country of residence: ____

2. Hospitalisation data

Date of first symptoms (dermal lesions)	________________ (dd/mm/yyyy)	
Date of first presentation to your hospital/clinic	________________ (dd/mm/yyyy)	
Date of admission	________________ (dd/mm/yyyy)	
Admitted from	home other hospital	If from other hospital, which one?: ____
Date of intensive care admission	________________ (dd/mm/yyyy)	none
Inotropic support	___________ (days)	
Ventilation (invasive and non-invasive)	___________ (days)	
Date of intensive care discharge	________________ (dd/mm/yyyy)	
Date of hospital discharge	________________ (dd/mm/yyyy)	
Discharged to	home other hospital	If to other hospital, which one?: ____

3. Clinical information

VZV-Exposure/transmission?	yes unknown	If yes, please specify: varicella herpes zoster
Exposure/transmission by whom?	sibling parent grandparent outside family	If outside family, please specify: ____
Primary diagnosis for hospitalisation	Varicella associated ischemic Stroke* Congenital varicella Herpes zoster Varicella complications present **at** or **during** admission (*multiple options possible):* Skin/soft tissue abscess/ cellulitis Purpura fulminans Necrotising fasciitis Septic arthritis/osteomyelitis Other focal purulent collection (specify):__________________ Encephalitis Cerebellitis (Ataxia) Meningitis Disseminated coagulopathy Haemorrhagic varicella X-ray evidence of pneumonia X-ray evidence of pneumonitis	**Note:* *send detailed report to Swiss Neuropediatric Stroke Registry https://snpsr.neuropaediatrie.ch/* If, herpes zoster, which dermatome(s)?: ____ Final primary VZV associated diagnosis in words:

	Fulminant varicella (multi-organ involvement) Reye's Syndrome Hepatitis	
	Other primary diagnosis	Specify: ___________________________
VZV vaccination	yes no unknown*	If yes, when? Dose 1: _______________ (mm/yyyy) Dose 2: _______________ (mm/yyyy) *_Note:_ please make every effort to get the history of varicella immunization by asking for immunization records or contact paediatrician/GP*
Underlying primary immunodeficiency	no yes	If yes, specify: ___________________________
Immunosuppressive treatment(s)	no yes	If yes, specify medication(s): ___________________________
Other significant chronic underlying diseases	no yes	If yes, specify: ___________________________

4. Diagnostics

Type	Done	Not done	Date	Result	
1st Serology				IgG positive	IgM positive
2nd Serology				IgG positive	IgM positive
VZV PCR (from lesions)				positve negative	
Other pos. VZV PCR				Specify site: _______________	
Blood culture			If positive:	Specify pathogen : ___________	
CSF culture (liquor)			If positive:	Specify pathogen : ___________	
Other site culture			If positive:	Specify site and pathogen: ___________________________	

5. Treatment

Antiviral treatment	i.v	yes no	Drug name: _______________________	_________ (days)
Antiviral treatment	p.o	yes no	Drug name: _______________________	_________ (days)
Antimicrobial treatment	i.v	yes no	Drug name: _______________________	_________ (days) Reason?:_______________
Antimicrobial treatment	p.o	yes no	Drug name: _______________________	_________ (days) Reason?:_______________
Antifungal treatment	i.v	yes no	Drug name: _______________________	_________ (days) Reason?:_______________
Antifungal treatment	p.o	yes no	Drug name: _______________________	_________ (days) Reason?:_______________
Other relevant treatment		yes no	Drug name: _______________________	_________ (days) Reason?:_______________
Surgical intervention		yes no	Specify (type, amount): ____	

6. Outcome

Healed Improved	
Sequelae	Specify: ____
Exitus letalis	Date of death: _______________ (dd/mm/yyyy) Was VZV the cause of death? yes no If no, other cause: ___________________________

Thank you for your valuable help and collaboration!
Please send this form back via e-mail to: studiensekretariat.paediatrie@luks.ch