Neonatal Varicella Infection

Australian Paediatric Surveillance Unit

If you have any questions about this form, please contact the APSU at email SCHN-APSU@health.nsw.gov.au

APSU Office Use Only

Study ID #:

Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. DK=Don't Know; NA = Not Applicable

Version: 2.2 10.12.2025

REPORTING CLINICIAN

1. APSU Dr Code/Name: ___ ___ ___ ___ / _____

Provide your best organisational email address: _____

2. Month/Year of Report: _____ / ___ ___ ___ ___

3. Date questionnaire completed: ___ ___ /___ ___ / ___ ___ ___ ___

PATIENT

4. First 2 letters of first name: ___ ___

5. First 2 letters of surname: ___ ___

6. Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

7. Sex:
- ☐ Male
- ☐ Female

8. Post code: ___ ___ ___ ___

9. Date of diagnosis: ___ ___ (month) ___ ___ ___ ___ (year)

10. Birth weight *(if known):* _____ grams

11. Gestational age at birth *(if known):* _____ weeks

12. Country of Birth:
- ☐ Australia
- ☐ Other, specify: _____
- ☐ Don't know

13. Mother's country of birth:
- ☐ Australia
- ☐ Other, specify: _____
- ☐ Don't know

14. Father's country of birth:
- ☐ Australia
- ☐ Other, specify: _____
- ☐ Don't know

15. Is the child of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No ☐ Don't know

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If this patient is primarily cared for by another physician whom you believe will report the case, please write the other physician's name and complete questionnaire details above this line and return.

If no other report is received for this child we will contact you for further information.

Please keep the patient's name and other details on your APSU file.

The primary clinician caring for this child is: ***Name:*** ***Hospital:***

Instructions: Please answer each question by ticking the appropriate box or writing your response in the space provided. DK= Don't Know, NA = Not applicable

Section A: Diagnosis of neonatal varicella infection

16. How was varicella infection diagnosed in the infant?
- ☐ Clinical
- ☐ Laboratory
- ☐ Both

17. If laboratory, which tests were +ve? *(tick all that apply)*
- ☐ Culture
- ☐ PCR
- ☐ EM
- ☐ IF
- ☐ Serology

xx. Has varicella genotyping being performed? ☐ Yes ☐ No ☐ Don't know

If Yes, Type: _____

If NO, is there any leftover specimen available for Genotyping? ☐ Yes ☐ No ☐ Don't know

18. a. Give age when illness commenced: _____

b. Approximate duration of illness: _____ days

c. Did the infant spend time in hospital due to varicella? ☐ Yes ☐ No ☐ Don't know

If Yes, number of days in hospital: _____ days

e. Was the infant admitted to ICU/HDU? ☐ Yes ☐ No ☐ Don't know

If Yes, number of days in ICU/HDU: _____ days

Section B: Clinical Features that can be attributed to varicella

19. Did the child have any of the following? *(please tick all that apply)*

a. Skin lesions consistent with varicella ☐ Yes ☐ No ☐ Don't know

b. Bacteraemia / septic shock ☐ Yes ☐ No ☐ Don't know

c. Toxic shock / toxin mediated disease ☐ Yes ☐ No ☐ Don't know

d. Necrotising fasciitis ☐ Yes ☐ No ☐ Don't know

e. Encephalitis ☐ Yes ☐ No ☐ Don't know

f. Purpura fulminans ☐ Yes ☐ No ☐ Don't know

g. Disseminated coagulopathy ☐ Yes ☐ No ☐ Don't know

h. X-Ray evidence of pneumonia ☐ Yes ☐ No ☐ Don't know

i. Fulminant varicella (multi-organ involvement) ☐ Yes ☐ No ☐ Don't know

j. Reye's Syndrome ☐ Yes ☐ No ☐ Don't know

k. Hepatitis ☐ Yes ☐ No ☐ Don't know

l. Other *(please specify)* _____

20. If there is/was concurrent or secondary infection state site of infection, sample type and organism:

Site	Sample Type	Organism
e.g. brain	*e.g. CSF*	*e.g. Staphylococcus Aureus*

Section C. Underlying medical conditions

21. Is the patient immunocompromised? ☐ Yes ☐ No ☐ Don't know

If yes, specify: _____

22. Has the patient any other significant underlying illness? ☐ Yes ☐ No ☐ Don't know

If yes, specify: _____

Section D. Management

23. Did the child receive any specific treatment?

☐ Yes
☐ No – ***go to section E***
☐ Don't know – ***go to section E***

24. Antiviral agent? ☐ Yes ☐ No ☐ Don't know

If yes, please specify in the table below:

	Date of first dose	Dose	Date ceased
☐ Aciclovir			
☐ Famiciclovir			
☐ Valaciclovir			

25. Zoster Immune Globulin?
☐ Yes – date: _____ / _____ / _____
☐ No
☐ Don't know

26. Other treatments?
☐ Yes ☐ No ☐ Don't know

If yes, please describe:
_____
_____

Section E. Outcome

27. What is the patient's current status?
☐ Still hospitalised – *go to* ***question 28***
☐ Dead – *go to* ***question 27a***
☐ Discharged alive – *go to* ***question 27b***

(a) If the child died, was varicella, or its complications, a cause of death?
☐ Yes ☐ No ☐ Don't know

(b) If the child was discharged, were there any ongoing problems on discharge?
☐ Yes ☐ No ☐ Don't know

If yes, please specify:
_____
_____

Section F. About Exposure to Varicella of Mother and Infant

28. Was there a history of varicella exposure for the infant?
☐ Intrauterine – *go to* ***question 29***
☐ Postnatal – *go to* ***question 32***
☐ No – *questionnaire is finished – thank you*
☐ Don't know – *questionnaire is finished – thank you*

29. During pregnancy, did the mother have contact with someone infected with varicella?
☐ Yes ☐ No ☐ Don't know

If yes, gestation in weeks from LMP:
_____ weeks

30. Was maternal varicella infection confirmed by laboratory testing?
☐ Yes ☐ No ☐ Don't know

If Yes, which laboratory tests were +ve?
☐ Culture
☐ PCR
☐ EM
☐ IF
☐ Serology

31. Did the mother have a varicella-like illness in Pregnancy?
☐ Yes ☐ No ☐ Don't know

(a) ***If yes***, stage of pregnancy in weeks from LMP:
_____ weeks

(b) What treatment was provided to the mother for the varicella-like illness?
☐ Zoster immune globulin
☐ Aciclovir
☐ Famciclovir
☐ Valaciclovir
☐ None
☐ Don't know
☐ Other *(specify):* _____

32. Who was the contact? (e.g. friend, relative)
_____ ☐ Don't know

If Contact was a child please give age:
_____

33. Was this contact living in the same household as the mother or affected infant?
☐ Yes ☐ No ☐ Don't know

34. Was the contact vaccinated against varicella?
☐ Yes ☐ No ☐ Don't know

Thank you for your assistance with this research project

Please return this questionnaire to the APSU via email to SCHN-APSU@health.nsw.gov.au
or by mail to: Australian Paediatric Surveillance Unit, Kids Research, Locked Bag 4001, Westmead NSW 2145
or via Fax: (02) 9845 3082

The APSU is affiliated with the Royal Australasian College of Physicians (Paediatrics and Child Health Division) and Faculty of Medicine and Health, The University of Sydney.
The APSU is funded by the Australian Government Department of Health.
This study has been approved by a Human Research Ethics Committee properly constituted under NHMRC guidelines