



VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella to your local or regional health office. You can fax a copy of this document to Denton County Public Health at (940) 349-5078. Please complete as many of the questions as possible. A report can still be submitted if all questions cannot be answered.

PATIENT INFORMATION:

Last Name: \_\_\_\_\_ First: \_\_\_\_\_
DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Sex: \_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_
Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

DEMOGRAPHICS:

Race: [ ] White [ ] Black or African-American [ ] Asian
[ ] Pacific Islander [ ] Native American/Alaskan [ ] Unknown
Hispanic: [ ] Yes [ ] No [ ] Unknown
Place of Birth: [ ] U.S.A. [ ] Other \_\_\_\_\_
Is the patient pregnant? [ ] Yes [ ] No [ ] Unknown

REPORTING INFORMATION:

Name of Person Reporting: \_\_\_\_\_
Agency/Organization Name: \_\_\_\_\_
Phone: \_\_\_\_\_
Address: \_\_\_\_\_
City: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_
Date Reported: \_\_\_/\_\_\_/\_\_\_
Health Department: \_\_\_\_\_

Did patient visit a healthcare provider during this illness?

[ ] Yes Date: \_\_\_/\_\_\_/\_\_\_ [ ] No
Physician: \_\_\_\_\_

Did the patient develop any complications? [ ] Yes [ ] No
Specify: \_\_\_\_\_

Is the patient immunocompromised? [ ] Yes [ ] No

Treated with any antiviral for this illness? [ ] Yes [ ] No
If yes, specify: \_\_\_\_\_ Start date: \_\_\_/\_\_\_/\_\_\_

Was the patient hospitalized for this disease?

[ ] Yes\* [ ] No \*If yes, please send medical records.
Hospital: \_\_\_\_\_
Admit date: \_\_\_/\_\_\_/\_\_\_ Discharge date: \_\_\_/\_\_\_/\_\_\_

Is this patient a contact to another known varicella or shingles case?

[ ] Yes [ ] No [ ] Unknown
Name of contact: \_\_\_\_\_ Phone: \_\_\_\_\_
Outbreak? [ ] Yes [ ] No

CLINICAL DATA:

Illness Onset Date \_\_\_/\_\_\_/\_\_\_ Illness duration: \_\_\_ days

Rash Onset Date \_\_\_/\_\_\_/\_\_\_

Rash Location: [ ] Generalized [ ] Focal [ ] Unknown

If generalized, first noted: (check all that apply)
[ ] Face/head [ ] Legs [ ] Trunk [ ] Arms [ ] Inside Mouth
[ ] Other (specify) \_\_\_\_\_

If focal, specify dermatome: \_\_\_\_\_

Number of lesions:

[ ] <50 (specify) \_\_\_\_\_ [ ] 50-249 [ ] 250- 499 [ ] 500+
If <50, how many of each:
[ ] Macules # [ ] Papules # [ ] Vesicles #

Did the rash crust? [ ] Yes, rash lasted \_\_\_ days before crusting
[ ] No, rash lasted \_\_\_ days [ ] Unknown

Fever? [ ] Yes, temperature \_\_\_°F
Date of Fever onset: \_\_\_/\_\_\_/\_\_\_ No. of days \_\_\_
[ ] No
[ ] Unknown

Character of Lesions:

Mostly Macular/Papular? [ ] Yes / [ ] No / [ ] Unknown
Mostly Vesicular? [ ] Yes / [ ] No / [ ] Unknown
Hemorrhagic? [ ] Yes / [ ] No / [ ] Unknown
Itchy? [ ] Yes / [ ] No / [ ] Unknown
Scabs? [ ] Yes / [ ] No / [ ] Unknown
Crops/Waves? [ ] Yes / [ ] No / [ ] Unknown

LABORATORY DATA: Testing done? [ ] Yes [ ] No [ ] Unknown

Ordering Facility: \_\_\_\_\_
[ ] DFA Result: \_\_\_\_\_ Date of test: \_\_\_/\_\_\_/\_\_\_
[ ] PCR Result: \_\_\_\_\_ Date of test: \_\_\_/\_\_\_/\_\_\_
[ ] Culture Result: \_\_\_\_\_ Date of test: \_\_\_/\_\_\_/\_\_\_
[ ] IgM Result: \_\_\_\_\_ Date of test: \_\_\_/\_\_\_/\_\_\_
[ ] IgG Acute Result: \_\_\_\_\_ Date of test: \_\_\_/\_\_\_/\_\_\_
Conv Result: \_\_\_\_\_ Date of test: \_\_\_/\_\_\_/\_\_\_

Previous History of Disease? [ ] Yes [ ] No

Date of Disease \_\_\_/\_\_\_/\_\_\_ Age at diagnosis: \_\_\_ years
Diagnosed by who:
[ ] Parent/friend [ ] Physician/Health Care Provider [ ] Other

Varicella Vaccination? [ ] Yes [ ] No

Number of Doses Received? [ ] 1 [ ] 2 [ ] 3
Date(s) of Varicella Vaccine:
1st Dose: \_\_\_/\_\_\_/\_\_\_ Type: [ ] MMRV [ ] Varicella
2nd Dose: \_\_\_/\_\_\_/\_\_\_ Type: [ ] MMRV [ ] Varicella

Did the patient attend: [ ] School [ ] Day Care [ ] Work [ ] College [ ] Other \_\_\_\_\_

Name of institution: \_\_\_\_\_ City: \_\_\_\_\_

Transmission Setting (Setting of Exposure): [ ] Athletics [ ] College [ ] Community [ ] Correctional Facility [ ] Day Care [ ] Doctor's office [ ] Home [ ] Hospital ER [ ] Hospital Outpatient Clinic [ ] Hospital Ward [ ] International Travel [ ] Military [ ] Place of Worship [ ] School [ ] Work [ ] Unknown [ ] Other \_\_\_\_\_