Texas Department of State Health Services

NBS ID:_______________ Case Investigation ID: CAS_________________TX01

VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella to your local or regional health office, or you can fax a copy of this document to the Texas Department of State Health Services in Austin at (512) 776-7616 at the end of every week. 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 ____________