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

**REPORTING INFORMATION:**

- Name of Person Reporting: _______________________
- Agency/Organization Name: _______________________
- Phone: ______________
- Address: _____________________________________
- City: ________________ Zip: ____________
- County: ________________
- Date Reported: ___/___/_____

**Did patient visit a healthcare provider during this illness?**

- [ ] Yes [ ] No Date: ___/___/_____
- Physician: ___________________

**Did the patient develop any complications?**

- [ ] Yes [ ] No

**Treated with any antiviral for this illness?**

- [ ] Yes (specify) _______________ [ ] No

**CLINICAL DATA:**

- Illness Onset Date ___/___/_____
- Rash Onset Date ___/___/_____
- Rash Location: [ ] Generalized [ ] Focal [ ] Unknown
  - [ ] Face/head [ ] Legs [ ] Trunk [ ] Arms [ ] Inside Mouth
  - [ ] Other (specify) _______________
  - If focal, specify dermatome: _______________

**Number of lesions:**

- [ ] <50 (specify) _______________
- [ ] 50-249
- [ ] 250-499
- [ ] 500+

**LABORATORY DATA:**

- Laboratory Testing done? [ ] Yes [ ] No [ ] Unknown
- Date of test: ___/___/____
  - [ ] DFA Result: __________
  - [ ] PCR Result: __________
  - [ ] Culture Result: __________
  - [ ] IgM Result: __________
  - [ ] IgG Result: __________

**History of Disease?**

- [ ] Yes [ ] No
- Date of Disease ___/___/_____

**Varicella Vaccination?**

- [ ] Yes [ ] No

**Number of Doses Received?**

- [ ] 1 [ ] 2
- Date(s) of Varicella Vaccine:
  - 1st Dose: ___/___/_____
  - 2nd Dose: ___/___/_____

**Was the patient hospitalized for this disease?**

- [ ] Yes [ ] No
- Hospital: ___________________
- Admit date: ___/___/_____
- Discharge date: ___/___/_____

**Fever?**

- [ ] Yes, temperature _______ °F
- [ ] No
- [ ] Unknown

**Character of Lesions:**

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

**Character of Lesions:**

- If macular/papular:
- [ ] Generalized [ ] Focal [ ] Unknown
- If focal, specify dermatome: _______________

**Did the rash crust?**

- [ ] Yes, rash lasted ______ days before crusting [ ] No, rash lasted ______ days [ ] Unknown

**Did the patient attend:**

- [ ] School [ ] Day Care [ ] Work [ ] College [ ] Other _______________
- Name of institution: _______________________
- City: ________________

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TEXAS DEPARTMENT OF STATE HEALTH SERVICES
EMERGING AND ACUTE INFECTIOUS DISEASE BRANCH

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