TEXAS Health and Human Services | 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

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: ____/____/_____

REPORTING INFORMATION:

Name of Person Reporting: _____

Agency/Organization Name: _____

Phone: _____

Address: _____

City: _____ Zip: _____ County: _____

Date Reported: ___/___/_____

Health Department: _____

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 (*complete the Varicella Outbreak Report Form, one per outbreak)

**NEDSS Outbreak Name: _____

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 whom:

☐ 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 _____