TEXAS Health and Human Services | Texas Department of State Health Services

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

Was the patient hospitalized for this disease?

☐ Yes ☐ No

Hospital: _____

Admit date: ____/___/____

Discharge date: ___/___/____

CLINICAL DATA:

Illness Onset Date ____/____/_____

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+

Did the rash crust? ☐ Yes, rash lasted _____ days before crusting ☐ No, rash lasted ____days ☐ Unknown

Fever? ☐ Yes, temperature _____°F

Date of Fever onset: ____/____/_____

☐ 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

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: ____/____/____ Type: _____

2nd Dose: ____/____/____ Type: _____

Did the patient attend: ☐ School ☐ Day Care ☐ Work ☐ College ☐ Other_____

Name of institution: _____ City: _____