

Health Services

Texas Department of State **VARICELLA** (chickenpox) Reporting Form

Please use this form to report cases of varicella to your regional health office at 254-778-6744, or you can fax a copy of this document to the Texas Department of State Health Services Region 7 office at 254-899-0405. Please complete as many of the questions as possible. A report can still be submitted if all questions cannot be answered.

Last Name: First:	PATIENT INFORMATION:	REPORTING INFORMATION:	
Address:	Last Name: First:	Name of Person Reporting:	
Zip Code: Phone:	DOB:// Age: Sex:	Agency/Organization Name:	
Zip Code: Phone: Address: DEMOGRAPHICS: Address: City: Zip: Race: White Black or African-American D Asian D Pacific City: Zip: Islander D Native American/Alaskan D Unknown Date Reported: /	Address: City:		
DEMOGRAPHICS: Race: White □ Black or African-American □ Asian □ Pacific Islander □ Native American/Alaskan □ Unknown City: Zip: County: Hispanic:: □ Yes □ No □ Unknown Date Reported: _/_/ Date Reported: _/_/ Did patient visit a healthcare provider during this illness? Vas the patient hospitalized for this disease? □ Yes □ No □ Yes □ No □ Date:/ Physician: Did the patient develop any complications? □ Yes □ No Hospital: □ Yes (specify) □ No Did the rash crust? □ Yes, rash lasted days before crusting □ No, rash lasted If generalized, first noted: (check all that apply) □ Unknown □ face/head □ Legs □ Trunk □ Arms □ Inside Mouth □ Other (spocify) □ So:249 □ 250-499 □ 500+ Character of Lesions:	Zip Code: Phone:		
Rade: Unline Losiack of Artical-Anthencial Disking Losion Lislander Naile American Alaskan Unknown Date Reported:/ Did patient visit a healthcare provider during this illness? Vas the patient hospitalized for this disease? I Yes No Physician:	DEMOGRAPHICS:	City: Zip:	
Hispanic: □ Yes □ No □ Unknown Date Reported:/ Did patient visit a healthcare provider during this illness? Was the patient hospitalized for this disease? □ Yes □ No Date:/ □ Yes □ No Physician:			
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: Bid the rash crust? Yes, rash lasted days before rusting Date / Rash Onset Date/ Breachead Date/ Pres (specify) Breachead Date/ Breachead Date/ Prese (specify) Breachead Date/		County:	
Yes No Date:/ Physician:		Date Reported://	
Image:	Did patient visit a healthcare provider during this illness?	Was the patient hospitalized for this disease?	
Privsician:	□ Yes □ No Date://	□Yes □No	
Did the patient develop any complications? Yes No Discharge date:// Treated with any antiviral for this illness? Discharge date:// [Yes (specify) No Did the rash crust? Yes, rash lasted days before crusting No, rash lasteddays Unknown Rash Onset Date/ Fever? Yes, temperature°F Rash Location: Generalized Focal Unknown Date of Fever onset:/ If generalized, first noted: (check all that apply) Unknown Face/head Legs Trunk Arms Inside Mouth Character of Lesions: Other (specify) Mostly Vesicular? Yes / No Number of lesions: Mostly Vesicular? Yes / No LABORATORY DATA: History of Disease? Yes No Varicella Vaccination? Yes / No Laboratory Testing done? Yes No Unknown Date of Disease? Yes No Varicella Vaccination? Yes / No DFA Result:	Physician:		
Image: Specify image	Did the patient develop any complications? Yes No		
CLINICAL DATA: Did the rash crust? Yes, rash lasted days before crusting No, rash lasted days Unknown Rash Onset Date/	Treated with any antiviral for this illness?	u	
Illness Onset Date// fill the rash Crust? = ites; fash itasted days belove crusting = No, rash lasted days = Unknown Rash Onset Date/ fever 0 (specify) = 0 (□Yes (specify) □ No		
Rash Onset Date	CLINICAL DATA:	Did the rash crust?	rash lasted days before
Rash Location: Generalized Focal Unknown Date of Fever onset://	Illness Onset Date//	crusting □ No, rash lasteddays □ Unknown	
Hash Location: Generalized Focal Uhknown \ No If generalized, first noted: (check all that apply) Uhknown Face/head Legs Trunk Arms Inside Mouth Character of Lesions: \ Yes / No Other (specify) Mostly Macular/Papular? Yes / No If focal, specify dermatome: Mostly Vesicular? Yes / No Number of lesions: Itchy? Yes / No 50-249 250-499 500+ Scabs? Yes / No LABORATORY DATA: History of Disease? Yes No Yes / No Laboratory Testing done? Yes No Uhknown Date of Disease? Yes No DFA Result: //	Rash Onset Date//		
□ Face/head □ Legs □ Trunk □ Arms □ Inside Mouth Character of Lesions: □ □ Other (specify) Mostly Macular/Papular? □ Yes /□ No If focal, specify dermatome: Mostly Vesicular? □ Yes /□ No Mumber of lesions: □ 50-249 □ 250-499 □ 500+ Scabs? □ Yes /□ No □ <50 (specify)	Rash Location: Generalized Focal Unknown		
□ Other (specify)	If generalized, first noted: (check all that apply)		
If focal, specify dermatome: Mostly Vesicular? Yes/□No Number of lesions: Yes/□No □<50 (specify)		Character of Lesions:	
Number of lesions: \$\sigma < 50 (specify)	□ Other (<i>specify</i>)		
Number of lesions: Itchy? \u00ed Yes \u00ed No \u00ed <50 (specify)	If focal, specify dermatome:	-	
LABORATORY DATA: Laboratory Testing done? Yes No Unknown Date of test:// BOFA Result: PCR Result: DIFA Result: Date of Disease Received? 1 2 Date(s) of Varicella Vaccine: 1 lgM Result: 1 lgG Result: Did the patient attend: School Day Care Work College Other	Number of locions:	•	
LABORATORY DATA: History of Disease? □ Yes □ No Laboratory Testing done? □ Yes □ No □ Unknown Date of test:// Date of test:// / □ DFA Result: PCR Result: □ PCR Result: Date of Doses Received? □ 1 □ 2 □ QBM Result: Date (s) of Varicella Vaccine: □ IgM Result: 1 lgG Result: □ IgG Result: 2 nd Dose:// Type: Did the patient attend: □ School □ Day Care □ Work □ College □ Other	$\Box < 50 \text{ (specify)}$ $\Box 50-249 \Box 250-499 \Box 500+$	Scabs?	□ Yes / □ No
Laboratory Testing done? □ Yes □ No □ Unknown Date of Disease// Date of test:// Date of Disease// □ DFA Result: Result: □ PCR Result: Date of Doses Received? □ 1 □ 2 □ Laboratory Testing done? □ Yes □ No Number of Doses Received? □ 1 □ 2 □ DFA Result: Date (s) of Varicella Vaccine: □ Culture Result: 1 gG Result: □ IgG Result: 2 nd Dose:/ Type: Did the patient attend: □ School □ Day Care □ Work □ College □ Other		Crops/Waves?	□ Yes / □ No
Laboratory resulty done? Test Test Test Test Test No Date of test:	LABORATORY DATA:		
DFA Result: PCR Result: Culture Result: IgM Result: IgG Result: Did the patient attend: School Day Care Work College Other		Date of Disease//	
□ PCR Result: □ Culture Result: □ IgM Result: □ IgG Result: □ IgG Result: □ Did the patient attend: □ School □ Day Care □ Work □ College □ Other	Date of test://	Varicella Vaccination? Ves No	
□ Culture Result:	DFA Result:		
□ IgM Result: 2 nd Dose: Type: □ IgG Result: 2 nd Dose: Type: Did the patient attend: □ School □ Day Care □ Work □ College □ Other	□ Culture Result:		
Did the patient attend: School Day Care Work College Other	□ IgM Result:	2 nd Dose:// Type:	
Name of institution: City:	Did the patient attend: □ School □ Day Care □ Work □ College □ Other		
	Name of institution: City:		