

PATIENT INFORMATION

**CLINICAL INFORMATION** 

## Texas Department of State Health Services

## **HEALTH SERVICE REGION 8**

Date of Report
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## VARICELLA REPORTING FORM

Last Name	First Name					DOB	☐ Male	
						Age	☐ Female	
Street Address	City				State	Zip	County	
Home Phone			] Black [ ] American Indian ve Hawaiian/ Pacific Islander		Reporting Provider			
( )	[] Othe	r, specif	fy:	Provider P		none ()		
Country of Birth	Ethnicity: [] Hispanic [] Non-Hispanic				hoon in the	II S for over 2 wee	oke 2	
Country of Birtii	☐ Yes	f born outside the U.S., has the patient been in the U.S. for over 2 weeks?  ☐ Yes ☐ No ☐ Unknown						
Illness Onset Date:	Location of Rash: □Generalized □ Focal □Unknown							
Illness onset defined as date of first symptoms (fever, rash, malaise)								
Rash Onset Date:            Number of Lesions:         □ 50-249         □ 250-499         □ >500								
Illness End Date:	If less than 50 lesions, specify number of each:							
Did patient have fever? ☐ Yes ☐ No Macules (flat): Papules (raised):								
Date of fever onset: Highest tem	p: Vesicles (fluid):							
Character of lesions: ☐Macular/Papular	er of lesions: □Macular/Papular □Vesicular □Hemorrhagic □Itchy □ Scabs □Crops/Waves							
Did the rash crust? □Yes □No								
	Yes	No	Unk					
Is patient immunocompromised?				Condition:				
Did patient visit a healthcare provider?				Date of Clinic Visit:				
Did patient develop complications?				Type of complica	e of complication:			
Was patient treated with antiviral?				Name of antivira	ıl:			
Was patient hospitalized for this illness?				Name of hospita	l:			
Did patient receive varicella vaccine?				If no, why?				
Number of vaccinations				Dates vaccinated	d: 1	2	3	
					4	5		
Does patient have history of disease?				Date of prior di	sease:			
Is patient a healthcare worker?				Employer:				
Is patient associated with school or daycare	? 🗆			Name of facility:				
Last day attended:				Grade:	Teacher:_			
Contacts with similar illness?				Who?				
Was lab testing done? ☐ Yes ☐ No ☐ Unk								
Type of test: Date	:	Result:						
Name of Laboratory:								
1								

LABORATORY

**Please Fax to 210.692.1457.** Call 210.949.2000 with any questions. Thank you.

Revised 03/13/2017