VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella to your local or regional health office. 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.

Onset Date _____/_____/_____ **Last day of school attended** _____/_____/_____	**History of Disease?** Yes No **Date of Disease** _____/_____/_____ **Vaccinated against Varicella?** Yes No **Number of Doses Received?** 1 2 **Date(s) Varicella Vaccine Administered:** (1) _____/_____/_____ (2) _____/_____/_____			
LAST NAME	**FIRST**	**DOB**	**AGE**	**SEX**
ADDRESS	**CITY**		**ZIP CODE**	
PHONE	**RACE**		**HISPANIC?** Yes No	
Is this patient a contact to another known Varicella case? **Name of contact:** **Phone:**	**Was the patient hospitalized?** Yes No		**Did the patient have a fever?** Yes No **Date:**	
Was lab testing done for Varicella? Yes No **Lab test: DFA PCR IgM IgG Other** **Date:**_____ **Result:** **Ordering Physician:**	**Number of lesions in total:** ***(circle number of lesions)*** <50 50-249 250-499 500+		**Did the patient attend daycare/after school care?** Yes No **Name of Facility:**	

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Name of Person Reporting: _____ **PHONE:** _____

Agency/Organization Name: _____

Address: _____

CITY: _____ **ZIP:** _____ **COUNTY:** _____

DATE REPORTED: _____