

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.

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Onset Date	History of Disease?	Yes	No E	Date of Disease	e	_//_	_	
Last day of school	Vaccinated against Varicella?	Yes		Number of Dos			2	
attended	Date(s) Varicella Vaccine Administ	etered: (1)/(2)/						
						Ī		
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?		Was the patient hospitalized? Did			Did th	the patient have a fever?		
Name of contact:		Yes No			Yes No			
Phone:					Date:			
Was lab testing done for Varicella? Yes No		Number of lesions in total: Did the pati (circle number of lesions) care?			ent attend daycare/after school			
Lab test: DFA PCR IgM IgG Other		(circle number of lesions) care? <50 50-249 Yes						
Date: Result:		Name of Facility: 250-499 500+			cility:			
Ordering Physician:		230-433	300+					
	T							
Onset Date	History of Disease?	Vaa	No E	hata of Diagon	_	/ /		
Last day of school	Yes	Yes No Date of Disease /						
attended /	Vaccinated against Varicella?						_	
	Date(s) Varicella Vaccine Administ	erea. (1)		J(2)		.//_ 		
LAST NAME		FIRST		DOB		AGE	SEX	
ADDRESS		CITY		ZIP CODE				
PHONE		RACE				HISPANIC?		
						Yes	No	
le this nationt a contact	to another known Varicella case?	Was the nati	ent hospitalized	?	Did th	e patient have	a fever?	
Name of contact:			·		Yes No			
Phone:		Yes	No		Date:			
Was lab testing done for Varicella? Yes No		Number of le	esions in total	Did the nati	ent atter	nd daycare/afte	er school	
Lab test: DFA PCR IgM IgG Other		Number of lesions in total: (circle number of lesions) Did the patient attend daycare/after sch				3011001		
Date: Result:				Yes Name of Fa	Yes No Name of Facility:			
		250-499						
Ordering Physician:			BHOM					
Name of Person Rep				c:				
	Name:							
CITY: ZIP:COUNTY:								
DATE REPORTED: _								