

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 Arlington at (817) 264-4557 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:		Number of lesions in total: <i>(circle number of lesions)</i> <50 50-249 250-499 500+		Did the patient attend daycare/after school care? Yes No Name of Facility:
Ordering Physician:				

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Name of Person Reporting: _____ PHONE: _____

Agency/Organization Name: _____

Address: _____

CITY: _____ ZIP: _____ COUNTY: _____

DATE REPORTED: _____