Utah Public Health
Name of Local Health Department
Address of Local Health Department
Phone: ***(801) xxx-xxxx*** *Confidential Fax* ***(801) xxx-xxxx***
April 26, 2010

CHICKENPOX
Varicella

CONFIDENTIAL CASE REPORT

DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:

Address: City: State:

County: Zip: Date of birth: _____/_____/_____ Age:

Phone #1: Phone #2: Phone #3:

Gender: *(Circle one)* M F

Race: *(Check all that apply)*
□ White □ Black/Af. Am □ American Indian □ Unknown
□ Asian □ Alaskan Native □ Native Hawaiian or Pacific Islander

Ethnicity: □ Hispanic □ Not Hispanic □ Other □ Unknown

Parent/guardian name: Relationship:

Patient's occupation:

CLINICAL INFORMATION

Onset Date: _____/_____/_____ Clinician Name: Clinician Phone #:

Was patient hospitalized? Y N U Hospital:
Date of admission: _____/_____/_____ to _____/_____/_____
Medical record #:

Did patient die? Y N U Date of death: _____/_____/_____

If yes, fill out the Chickenpox Supplemental Death Questions

Date of rash onset: ___/___/___
Number of lesions: □ <50 □ 50-249 □ 250-499 □ ≥500 □ Unknown

Diagnosed by *(Choose one):*
□ Parent/guardian □ School □ Physician/health care worker □ Self □ Other _____

Has patient had chickenpox previously? Y N U
If yes, then list patient's age at prior diagnosis: _____
Is patient pregnant? Y N U
If yes has OB/GYN been notified? Y N U
Number of weeks gestation at the onset of illness: _____

VACCINATION HISTORY
Was patient vaccinated? Y N U
If yes, list number of doses _____
If no, list reason for not vaccinating:
□ Medical contraindication □ Religious exemption □ Philosophical objection
□ History of previous disease □ Never offered vaccine □ Outside recommended age range
□ Other _____

CHICKENPOX
Varicella

Patient name: _____ ID: _____

LABORATORY INFORMATION

Was PCR done? Y N U
Name of laboratory: _____ Date collected: _____/_____/_____
Sample collected: □ Vesicular swab □ Macular scraping □ Tissue culture □ Scab
Test results: *(Check one)*
□ Positive □ Inconclusive □ Negative □ Pending

Was DFA done? Y N U
Name of laboratory: _____ Date collected: _____/_____/_____
Sample collected: □ Vesicular swab □ Macular scraping □ Tissue culture □ Scab
Test results: *(Check one)*
□ Positive □ Inconclusive □ Negative □ Pending

Was culture done? Y N U
Name of laboratory: _____ Date collected: _____/_____/_____
Sample collected: □ Vesicular swab □ Macular scraping □ Tissue culture □ Scab
Test results: *(Check one)*
□ Positive □ Inconclusive □ Negative □ Pending

Was serology (IgM) done? Y N U
Name of laboratory: _____ Date collected: _____/_____/_____
Serology value: _____
Test results: *(Check one)*
□ Positive □ Inconclusive □ Negative □ Pending

Was serology (IgG) done? Y N U
Name of laboratory: _____ Date collected: _____/_____/_____
Serology value: _____
Test results: *(Check one)*
□ Positive □ Inconclusive □ Negative □ Pending

SCHOOL INFORMATION

Does patient attend or work in a school or daycare? Y N U
If yes, then:
Is patient associated with a daycare? Y N U
If yes list the name of the daycare: _____
Has the daycare administrator been notified? Y N U
Is patient associated with a school? Y N U
If yes list the name of the school: _____
List the teacher's name: _____
Has the school nurse been notified? Y N U
What grade is the patient associated with?
□ Kindergarten □ Grade school □ College
If grade school, list the grade: _____

CHICKENPOX SUPPLEMENTAL DEATH QUESTIONS
Fill this section out ONLY if patient has died.

Is patient a healthcare worker? Y N U
Is patient immunocompromised? Y N U
If yes, then specify _____
Was an autopsy performed? Y N U
If yes, list the official cause of death _____

COMPLICATIONS

Did patient develop any complications that were diagnosed by a healthcare provider? Y N U

Skin/soft tissue infection	Y	N	U
Encephalitis	Y	N	U
Cerebellitis/Ataxia	Y	N	U
Dehydration	Y	N	U
Hemorrhagic condition	Y	N	U
Pneumonia	Y	N	U
Congenital varicella syndrome	Y	N	U

TREATMENT

Did patient receive:

Acyclovir	Y	N	U
If yes, then date started ___/___/___			
Famciclovir	Y	N	U
If yes, then date started ___/___/___			
Valacyclovir	Y	N	U
If yes, then date started ___/___/___			
Varicella zoster immune globulin	Y	N	U
If yes, then date administered ___/___/___			

REPORTING

Reported by: *(Check all that apply)*
□ Hospital/ICP □ Clinic/doctor's office □ Lab □ General public □ Other _____

What is the date the lab reported to the clinician? _____/_____/_____

Reporter's name: _____ Phone number: _____

Reporter's agency: _____ Date reported to public health: _____/_____/_____

LHD Investigator: Phone: Date submitted to UDOH: _____/_____/_____

LHD Reviewer:

LHD Case classification: *(Check one)*
□ Confirmed □ Probable □ Suspect □ Pending □ Out of state □ Not a case

UDOH Case Classification:
□ Confirmed □ Probable □ Suspect □ Pending □ Out of state □ Not a case