



Rhode Island Department of Health Varicella (Chickenpox) Case Report Form

REPORTING INFORMATION			
DATE OF REPORT:	NAME OF PERSON REPORTING:	PHONE:	FAX:
REPORTING SITE IS: <input type="checkbox"/> Physician <input type="checkbox"/> School <input type="checkbox"/> Daycare <input type="checkbox"/> College <input type="checkbox"/> Other _____		ADDRESS/CITY	
DEMOGRAPHIC INFORMATION			
PATIENT LAST NAME	FIRST NAME	DATE OF BIRTH:	SEX Male <input type="checkbox"/> Female <input type="checkbox"/>
STREET ADDRESS:	CITY:	ZIP CODE	PHONE:
RACE: <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
CASE ATTENDS: <input type="checkbox"/> School <input type="checkbox"/> Daycare <input type="checkbox"/> College <input type="checkbox"/> Work <input type="checkbox"/> Other _____ <input type="checkbox"/> Not applicable		NAME OF INSTITUTION:	CITY:
CLINICAL INFORMATION			
Rash onset date: ____/____/____ mm dd yy			
Severity (check one): <input type="checkbox"/> < 50 lesions (could be counted in 30 seconds) <input type="checkbox"/> 50-249 lesions (enough space without lesions, so if you put sick person's hand on that space, it will not be covering any lesions) <input type="checkbox"/> 250 – 500 lesions (a typical case, can see normal skin between lesions) <input type="checkbox"/> > 500 lesions (the whole body is covered with lesions; confluent rash, unable to see normal skin between lesions) <input type="checkbox"/> Unknown			
Reliable prior history of chickenpox: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, age at previous disease: _____			
Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, hospital name: _____			
Diagnosed: Date: ____/____/____ By: <input type="checkbox"/> MD/PA/NP/RN <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> School <input type="checkbox"/> Self <input type="checkbox"/> Other			
Laboratory confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, Test type: <input type="checkbox"/> DFA <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> PCR <input type="checkbox"/> Other Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Undetermined <input type="checkbox"/> Unknown			
VACCINE INFORMATION			
Did case ever receive varicella vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, date(s) received varicella vaccination 1. ____/____/____ 2. ____/____/____			
Where did case reside between 12 and 18 months of age? <input type="checkbox"/> RI <input type="checkbox"/> Other State in US (specify) _____ <input type="checkbox"/> Outside US			

Please fax completed Varicella Case Report Form to Attn: Immunization Program at (401) 222-1442.