Chickenpox (Varicella) Case Report

Effective March 3, 2008 in compliance with Illinois Department of Public Health's Control of Communicable Disease Code (77 Illinois Administrative Code 690) each case of Chickenpox (Varicella) is now reportable within 24 hours of receipt of notification from a parent, guardian, or health care provider.

The following information should be collected and reported to **Kane County Health Department (KCHD), Communicable Disease Program via phone or fax**.

630-897-8128 fax or 630-208-3801 phone

REPORTER INFORMATION

Date of Report _____
Name of Employee Reporting _____
Facility Name_____
Facility Address_____ Facility Phone_____

CASE INFORMATION

Patient's Name _____
Age _____ Date of Birth _____ Race_____ Sex _____
Parent's Name(s) If applicable_____
Home Address _____
City _____ School/Daycare_____
Phone(s)_____
Physician's Name _____Physician's Phone _____

Date of Visit: _____ Rash Onset Date: ___/___/___

Date(s) of Varicella Vaccination
#1. ___/___/___ Vaccine type_____ Manufacturer_____ Lot #_____
#2. ___/___/___ Vaccine type_____ Manufacturer_____ Lot #_____

Rash Localized: Y ___N___ Rash Generalized: Y___ N____
Rash 1st developed on: *Arms*: Y__ N__ *Face/Head*: Y__ N__ *Legs*: Y__N__*Trunk*:Y__N__
Fever: Y ___ (if Yes, Fever Onset Date: __/__/__) N ___
Number Lesions: Less than 50 ___ Greater than 50 ___
Is the pt immunocompromised due to pre-existing medical condition or treatment? Y N
Identify any complications the pt developed:
Encephalitis: Y___N___ Pneumonia: Y___N___ Skin/Soft Tissue infection: Y___N__
Other: _____
Laboratory Testing done: Y_____ N_____
Were licensed antivirals given: Y_____N_____ Name of Antiviral:_____
Date Started: ___/___/___ Total Days taken:_____
Is pt pregnant: Y_____N_____ If Yes, EDC: ___/___/___

Varicella Worksheet (for Kane County Health Department staff use)

Pt. Name_____ B.D. _____

CONTACTS (including parents)

	1.	2.	3.	4.	5.
Name					
Date of Birth					
Relation to Case					
Place of Employment/School					
History of symptoms?					
Lab Confirmed?					
Vaccination/Disease History					
Comment					

POSSIBLE GROUP/FACILITY EXPOSURE

Group/facility/school Name: City: Attendance:
Last day pt was in attendance:____/____/_____
Control Measures:

Epi data

-Occupation: Name of Employer:
-Patients attends/resides in (type of facility):
-Day Care/Facility Name:
-Transmission Setting (Where did suspect acquire illness):
-Is this case linked to a confirmed or probable case? Y N Name:_____
-Was the patient excluded from facility (work, daycare, school, etc.) for a minimum of 5 days after appearance of eruption or until vesicles became dry? Y N Last day pt was in school/work:__/__/__
-Was pt seen in ER? Y N
-Was patient was hospitalized? Y N If yes, were they isolated? Y N
-If yes, Admit Date: ___/___/___ Discharge Date:___/___/___
-Name of Hospital:_____
-Were lesions crusted at time of interview? Y N
-Does pt have a previous history of cpox? Y N

NOTES: