Georgia Department of Public Health
Varicella Case Report Form

SendSS ID: _____

Form Complete □ Yes □ No

PATIENT DEMOGRAPHICS

Patient name: Last, First M.I.	Date of birth:(mm/dd/yy) ____/____/____	Age *(enter age and check one):* ____ □ Days □ Weeks □ Months □ Years		Gender: □ M □ F □ Other □ Unknown
Address: Number, Street	City:	State:	ZIP code:	County:
Telephone number: Home ( ) –	Work ( ) –		Country of birth:	

Ethnicity (check one):
□ Hispanic/Latino
□ Non-Hispanic/Latino
□ Unknown

Race (check all that apply):
□ Black/African-American
□ Asian /Pacific Islander
□ Unknown
□ Native American/Alaskan Native
□ Multiracial
□ White
□ Other (please specify)_____

TRACKING DATA

Medical record no. or client no.:	State Case ID ***(For state use only):***		
Date reported to health department (mm/dd/yy): ____/____/____	Date investigation started: ____/____/____	Person/clinician reporting:	Reporter telephone: ( ) –
Case investigator completing form:	Organization:	Investigator phone: ( ) –	

Event Date: ____/____/____

Event Type: □ Rash Onset Date □ Diagnosis Date □ Lab Test Date □ Unknown □ Report Date (County) □ Report Date (State)

SIGNS AND SYMPTOMS

Did the patient visit a healthcare provider during this illness? □ Yes □ No □ Unknown

Diagnosis date: ____/____/____	Illness onset date: ____/____/____	Rash: □ Yes □ No □ Unknown	Rash onset date: ____/____/____	Estimated number of lesions: □ < 50 □ 50-249 □ 250-500 □ > 500
Rash location: □ Generalized □ Focal □ Unknown	If focal, specify area(s) of body:	Where on body did rash 1st occur? (check all that apply) □ Face/Head □ Legs □ Trunk □ Arms □ Inside mouth □ Other (please specify)_____		

Character of lesions :

Macules (flat) present	□ Yes	□ No	□ Unknown
Papules (raised) present	□ Yes	□ No	□ Unknown
Vesicles (fluid) present)	□ Yes	□ No	□ Unknown
Hemorrhagic	□ Yes	□ No	□ Unknown
Itchy	□ Yes	□ No	□ Unknown
Scabs/crusting	□ Yes	□ No	□ Unknown
Crops/waves	□ Yes	□ No	□ Unknown

Did the rash crust over?
□ Yes □ No □ Unknown
If yes, how many days until all the lesions crusted over?
_____days (Uk=999)
If no, how many days did the rash last?
____days (Uk=999)

Fever? □ Yes □ No □ Unknown
Date of fever onset:
____/____/____
Highest measured temperature:
°F (Unknown-999.9)
Total number of days with fever:
_____ days
(Unknown=999)

VACCINATION AND DISEASE HISTORY

Ever received one or more doses of varicella containing vaccine?
□ Yes □ No □ Unknown

Number of doses **on** or **after** first birthday: _____ doses

Source of Vaccination History:
□ GRITS □Physician Record □Parent Held Record
□Patient Recall □Parent Recall □Other

Dose	Vaccination date	Vaccine type	Vaccine manufacturer	Lot number
Dose 1	____/____/____			
Dose 2	____/____/____			
Dose 3	____/____/____			
Dose 4	____/____/____			

Vaccine type codes: V: Varivax M: MMRV (ProQuad) U: Unknown O: Other

Manufacturer codes: M: Merck O: Other U: Unknown

Previous diagnosis of varicella?
□ Yes □ No □ Unknown

If previously diagnosed, age at previous diagnosis: _____ (Unknown=999) □ Days □ Weeks □ Months □ Years

Previous diagnosis made by: □ Parent □ Physician/Healthcare Provider □ Other _____

Reason for not being **age-appropriately** vaccinated:

□ Born outside the U.S. **(1)**
□ Lab evidence of previous disease **(2)**
□ MD diagnosis of previous disease **(3)**
□ Medical contraindication **(4)**
□ Never offered vaccine **(5)**
□ Parent/patient forgot to vaccinate **(6)**
□ Parent/patient refusal **(7)**
□ Philosophical objection **(8)**
□ Religious exemption **(9)**
□ Under age for vaccination **(10)**
□ Other **(11)** (specify) _____
□ Unknown **(12)**

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COMPLICATIONS

Hospitalized: □ Yes □ No □ Unknown	Dates hospitalized: ___/___/___ to ___/___/___ Total # days hosp: _____	Facility name:

Primary Reason for Hospitalization:

Did the patient develop any complications that were diagnosed by a healthcare provider? □ Yes □ No □ Unknown

Skin/soft tissue infection	□ Y□ N □ Unk	Dehydration	□ Y□ N □ Unk	Meningitis	□ Y□ N □ Unk
Cerebellitis/ataxia	□ Y□ N □ Unk	Hemorrhagic condition	□ Y□ N □ Unk	Other (please specify):	
Encephalitis	□ Y□ N □ Unk	Pneumonia	□ Y□ N □ Unk		

Does case-patient have any co-morbid medical condition(s)? □ Yes □ No □ Unknown	If Yes, specify co-morbid condition(s):
Is case-patient immunocompromised? □ Y □ N □ Unk	If Yes, list immunocompromising medications, conditions:

Death: □ Yes □ No □ Unknown	If yes, date of death: ____/____/____	**If case died, please complete and attach varicella death worksheet**

TREATMENT

Did the patient receive any antiviral treatment? □ Yes □ No □ Unk	Date treatment started: ___/___/___	No. of days treatment taken _____ (Unk=999)
Antiviral treatment received: □ Acyclovir □ Valacyclovir □ Famciclovir □ Other (specify)_____		

LABORATORY TESTS

Was laboratory testing done for varicella? □ Yes □ No □ Unknown	Case lab confirmed ***(For state use only)*** □ Yes □ No □ Unknown	Isolate/Specimen Available: □ Yes □ No

	Result	Date specimen taken	Lab name
Culture	_____	____/____/____	_____
PCR	_____	____/____/____	_____
IgM	_____	____/____/____	_____
IgG (acute)	_____	____/____/____	_____
IgG (convalescent)	_____	____/____/____	_____
DFA	_____	____/____/____	_____

Reason for **no** laboratory testing: **(check all that apply)**
□ Physician did not request testing
□ Rash was resolved at time of PH notification
□ Parental/Patient refusal
□ Other (specify) _____

**DPH requests lab testing on all vaccinated cases. However, lab confirmation is not a requirement to be considered a case.

Result Codes: P:Positive X:Not done N:Negative I:Indeterminate E:Pending U:Unknown S: Shingles

EPIDEMIOLOGIC INFORMATION

Epi-linked to another confirmed or probable case? □ Yes □ No □ Unknown

If yes, name of epi-linked case: _____

SendSS ID of epi-linked case: _____

Relationship to case: □ Other _____

□ Mother □ Brother □ Grandparent □ Cousin □ Sibling N/S
□ Father □ Neighbor □ Friend □ Aunt □ Unknown
□ Sister □ Daycare □ Baby Sitter □ Uncle

Has this case been in contact with anyone with shingles in the past 21 days?
□Yes : Relationship to case: _____ □No □Unk

Outbreak related? □ Yes □ No □ Unknown	Outbreak name or location:

Transmission setting (Where did this case acquire varicella?)

□ Daycare (1) □ Doctor's Office (8) □ Other (15)
□ School (2) □ Unknown (9) □ Work (3)
□ College (10) □ Hospital Ward (4) □ Military (11)
□ Hospital ER (5) □ Correctional facility (12)
□ Outpatient clinic (6) □ Place of worship (13)
□ Home (7) □ International travel (14)

Is the patient:
Pregnant? □ Y□ N □ Unk
If Yes, weeks pregnant: _____
Healthcare worker? □ N □ Unk
□ Yes, w/o direct patient contact
□ Yes, with direct patient contact
Employed at or attend daycare? □ Y□ N □ Unk
Employed at or attend school? □ Y□ N □ Unk
Incarcerated? □ Y□ N □ Unk
Institutionalized? □ Y□ N □ Unk
(nursing home or chronic care facility)

Was a final follow up call completed at the end of the 21 day incubation period to ensure no contacts developed disease?
□ Yes
□ No (reason) _____

No. of resident's in case's household: _____

Setting of further documented spread from case (outside of household) (use no. codes from transmission Q above) _____

Comments:

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