KANSAS VARICELLA (CHICKENPOX) REPORTING FORM

Fax this form to your local health department or KDHE: 877-427-7318

Please include varicella laboratory results, if available

To report urgent diseases, call the KDHE Epidemiology Hotline: 877-427-7317 This form is available at: www.kdhe.ks.gov/1492

Today’s date: ____________________________

PATIENT INFORMATION

Name: ____________________________________________

   Last          First          Middle

Mobile phone: ____________________________ Home phone: ____________________________

Residential address: _______________________________________________________________

City: ____________________________ State: __________ Zip: __________

Date of Birth (if unknown, provide age): ____________________________

Race: □ White          □ Black          □ Asian          □ American Indian / Alaska Native
       □ Native Hawaiian / Pacific Islander

Ethnicity: □ Hispanic          □ Non-Hispanic          □ Hispanic          □ Non-Hispanic

Sex: □ Male          □ Female          □ Pregnant? □ Yes          □ No          □ Unknown

Associated with high-risk setting or institution? □ Daycare          □ Health Care          □ Food Handler
       □ School          □ Nursing Home          □ Correctional          □ Shelter
       □ Other

Grade/Room: ____________________________

DISEASE OR CONDITION INFORMATION

Has the patient/guardian been notified of varicella diagnosis? □ Yes          □ No

Hospitalized? □ Yes          □ No          □ Unknown

Hospital: ____________________________________________________________

Died? □ Yes          □ No

Has any laboratory testing been performed? □ Yes (enter below)          □ No

Laboratory name: ____________________________ Specimen collection date: ____________________________

Test(s) performed: ____________________________ Test result(s): ____________________________

FACILITY AND PHYSICIAN INFORMATION

Facility name: ____________________________ Facility city: ____________________________

Physician name: ____________________________ Phone #: ____________________________

Name of person reporting: ____________________________ Phone #: ____________________________

PLEASE CONTINUE TO PAGE TWO FOR SUPPLEMENTAL INFORMATION FOR REPORTING VARICELLA
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SUPPLEMENTAL VARICELLA INFORMATION – CLINICAL SYMPTOMS

Rash onset date: __________________________ Number of lesions: □ <50 □ 50-249 □ 250-500 □ >500

Rash location: □ Generalized □ Focal □ Unknown

Description and characteristic of rash (select all that apply):

☐ Mostly macular/papular ☐ Mostly vesicular ☐ Hemorrhagic ☐ Pruritic (itchy)
☐ Resolved (crusted) ☐ Crops/waves ☐ Other: ____________________________

Patient febrile: □ Yes (Highest temp. __________ °F/C) ☐ No ○ Unknown

Patient immunocompromised: □ Yes (Describe: ____________________________ ) □ No ○ Unknown

SUPPLEMENTAL VARICELLA INFORMATION – VACCINATION STATUS

Has patient previously received any varicella-containing vaccine? □ Yes (enter below) □ No ○ Unknown

Vaccine One:
Date received: __________________________ Type: __________________________
Manufacturer: __________________________ Lot Number: __________________________

Vaccine Two:
Date received: __________________________ Type: __________________________
Manufacturer: __________________________ Lot Number: __________________________

If unimmunized (or under-immunized), please select reason(s) below:

☐ Medical contraindication ☐ Religious exemption ☐ Parental objection ☐ Alternative immunization schedule

☐ Philosophical objection ☐ Under age for vaccination (younger than 2 months) ☐ Unknown/other