



## 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.kdheks.gov/epi/disease\\_reporting.html](http://www.kdheks.gov/epi/disease_reporting.html)

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  
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

Name and city of high-risk setting or institution: \_\_\_\_\_ Grade/Room: \_\_\_\_\_

### DISEASE OR CONDITION INFORMATION

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

Hospitalized?  Yes → Hospital: \_\_\_\_\_ Died?  Yes  No  
 No  Unknown

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

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