BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY

CHICKENPOX (VARICELLA) CASE REPORT
PLEASE COMPLETE INFORMATION BELOW WHEN REPORTING AND
Fax this information to Deena Olds at 517-278-2923

Provider Office or School: _____

Patient Name:_____
Parent/Caregiver:*(required if under 18)*_____
Address:_____
Phone:_____ Alternate Phone:_____ School:_____
Sex: M F Age:_____ Date of Birth_____ Grade:_____

Race: Caucasian African American **Ethnicity:** Hispanic/ Latino
Hawaiian/Pacific Islander Asian Not Hispanic/Latino
American Indian/Alaska Native Unknown Unknown
Other (Specify)_____

Diagnosed by_____ Date Diagnosed_____

Varicella Vaccination History

Has patient received varicella vaccine? . . . . . YES NO UNKNOWN

If YES, date the vaccine was given_____ _____

Severity of illness (as reflected by approximate number of lesions):

Fewer than 50 (easily counted in 30 seconds)

50-249 (patient's hand can be placed somewhere on body without touching a lesion)

250-499 (patient's hand cannot be placed on body without touching one or more lesions)

500 or more (cannot observe normal skin)

DATE that spots were first noticed_____

You may wish to provide information to Communicable Disease Nurse by phone:

Coldwater	**Hillsdale**	**Three Rivers**
517-279-9561 **Ext 105**	517-437-7395 **Ext 110**	269-273-2161 **Ext 241**

For Office Use Only:

CHECKED/Verified MCIR/ CMHC YES

Person Submitting: _____

For Office (Circle): BR HD TR

DATE_____