

**New Jersey Department of Health  
Vaccine Preventable Disease Program  
PO Box 369  
Trenton, NJ 08625-0369**

**VARICELLA CASE REPORT**

Report Status <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Not a Case	
CDRSS#	E#

REPORTING INFORMATION			
Date Reported to LHD/State		Reported By	
Reporting Site/Clinic		Telephone No.	
Reporting Site/Clinic		Town/City	County
Type of Reporting Site <input type="checkbox"/> School <input type="checkbox"/> Day Care <input type="checkbox"/> Physician <input type="checkbox"/> Health Dept. <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other: _____			
DEMOGRAPHIC INFORMATION			
Name of Patient (Last) (First)		Date of Birth	Age
Address		Telephone Number	
City		Zip Code	County
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Alaskan/Native American <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____			
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Name of Parent/Guardian		Parent/Guardian Telephone No.	
Case Attends <input type="checkbox"/> School <input type="checkbox"/> Day Care <input type="checkbox"/> Work <input type="checkbox"/> College <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Other: _____			
Name of Institution		Have there been other cases at this site? <input type="checkbox"/> Yes – How Many? _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
City/County			
CLINICAL INFORMATION			
Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Is Final DX Shingles Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous History of Vaccination? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Previous History of Chickenpox? <input type="checkbox"/> Yes – Age: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If Yes, Date Administered: VZV Dose 1: _____		VZV Dose 2: _____	
Rash Onset Date	Fever? <input type="checkbox"/> Yes - Temperature: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cold Symptoms? <input type="checkbox"/> Yes - Onset Date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Rash Severity: <input type="checkbox"/> <50 lesions (can be counted in 30 seconds) <input type="checkbox"/> 50-249 lesions (enough skin without lesions that sick person's hand can be placed somewhere on skin and not cover any lesions) <input type="checkbox"/> 250-499 lesions (typical case, can see normal skin between lesions) <input type="checkbox"/> ≥500 lesions (whole body is covered with lesions; confluent rash, unable to see normal skin between lesions) <input type="checkbox"/> Unknown			
If less than 50, specify #: _____		Presentation of rash (select all that apply): <input type="checkbox"/> Vesicular <input type="checkbox"/> Maculopapular <input type="checkbox"/> Other: _____	
Name of Treating Physician		Telephone No.	
Laboratory Evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No		If Yes, Test Type: <input type="checkbox"/> DFA <input type="checkbox"/> PCR <input type="checkbox"/> IgM <input type="checkbox"/> Other: _____	
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Negative <input type="checkbox"/> Unknown			
Hospitalized? <input type="checkbox"/> Yes – Dates Hospitalized: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown If Yes, Hospital Name: _____			
Complications? <input type="checkbox"/> Yes – Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Patient Died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If Yes, Autopsy Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

## VARICELLA CASE REPORT

### (Continued)

[illegible]