VARICELLA (Chickenpox)
HERPES ZOSTER (Shingles)
CASE REPORT FORM (CRF)
FAX TO 312-746-6388
Phone: 312-746-5911

FINAL STATUS
❑ CONFIRMED ❑ SUSPECT
❑ PROBABLE ❑ NOT A CASE
OFFICIAL USE ONLY

Patient Name ______________________________
Address ______________________________
City ____________________ **Zip** ____________
Parent/Guardian ______________________________
Phone ____________________ **Cell** ____________________

Reported by ______________________________
Agency ______________________________
Address ______________________________
Phone ______________ **Fax** ______________
Date Reported ______________

Sex ☐ Male ☐ Female **Date of Birth**_____/____/_____ **Age** ______ ☐ Years ☐ Months ☐ Weeks ☐Days
Hispanic ☐ Yes ☐ No **Race:** ☐ Black ☐White ☐Nat. Am ☐ Asian/Pac Isl. ☐ Other ☐Unknown

OCCUPATION: ☐ Student; School ______________________ ☐ Healthcare worker; employer ______________________

CLINICAL

☐ **Primary Chickenpox** ☐**Herpes Zoster (shingles)**
Date of Service ______________ **Date of Diagnosis** ______________
Fever? ☐ Yes ☐ No **Fever onset date** __________ **Tmax** _______C°/F°
Rash? ☐ Yes ☐ No **Rash onset date** _____________ x _________ days
☐ Generalized ☐ Localized ☐ Along a dermatome
Rash location/s ☐ Head/Face ☐Trunk ☐ Back ☐ Legs ☐ Arms
Complications? ☐ Yes ☐ No; Complications: ______________________
Diagnosing Physician/Nurse ______________________________
Phone Number: ______________________

Estimate Lesion Severity
☐ < 50 lesions (mild)
☐ 50-249 lesions (mild/moderate)
☐ 250-500 lesions (moderate)
☐ >500 lesions (severe)

Was the patient seen in an ER? ☐ Yes ☐ No
ER Hospital:______________________
Date:____/______/_________
Patient admitted to a hospital? ☐ Yes ☐ No
Hospital: ______________________
Admitted: _____/_____/_____
Discharged: _____/_____/_____

LAB

Was laboratory testing done? ☐ Yes ☐ No
Laboratory used ______________________________
Specimen collection date __________________
Varicella DNA/PCR test result _______________
Serology result IgM__________ IgG ___________
DFA result______________ Other ____________

RX

Antiviral medications given? ☐ Yes ☐No
Name ____________________
Date Rx ____________________
Number of days ______________

IMMUNITY

Previous history of chickenpox disease? ☐ Yes ☐ No ☐ Unknown
If yes, physician diagnosed? ☐ Yes ☐ No Date of diagnosis/disease____________
Vaccinated with varicella vaccine? ☐ Yes ☐ No ☐ Unknown

	Vaccination Date	Type	Manufacturer	Lot Number
1	_____________	___________	__________________	__________
2	_____________	___________	__________________	__________

Reason not vaccinated:
☐ Religious exemption
☐ Medical contraindications
☐ Previous diagnosed disease
☐ Inappropriate age
☐ Parental refusal
☐ Other

Class I (b) report within 24hrs