Varicella Reporting Requirements
Reporters Guide

(1) Date of Report

Date form completed by Reporter

(2) Patient Name

Patient's last name, first name required, middle initial preferred

(3) Gender

This is not required, but *is* preferred

(4) Date of Birth

Patient's date of birth (Month, day, year)

(5) County of Residence

Enter Local Public Health Agency jurisdiction for case. If unsure of jurisdiction, provide Patient address

(6) Other Associated Cases

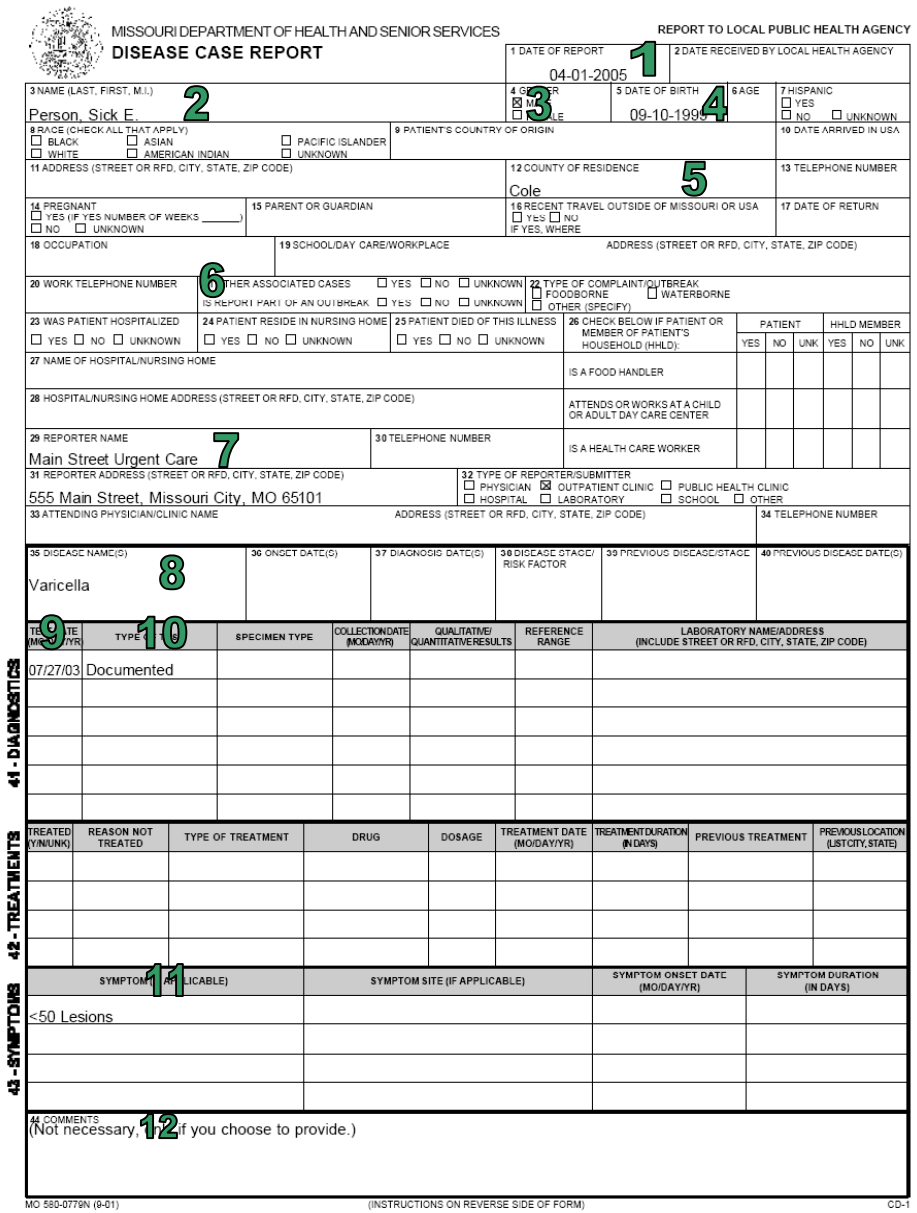
Check applicable box if other cases are or are not linked to the case being reported

(7) Reporter Name

Person/Entity reporting case

(8) Disease Name

Varicella entered here



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DISEASE CASE REPORT
REPORT TO LOCAL PUBLIC HEALTH AGENCY

1 DATE OF REPORT: 04-01-2005 (1)
2 DATE RECEIVED BY LOCAL HEALTH AGENCY
3 NAME (LAST, FIRST, M.I.): Person, Sick E. (2)
4 GENDER: ☒ MALE ☐ FEMALE (3)
5 DATE OF BIRTH: 09-10-1999 (4)
6 AGE
7 HISPANIC: ☐ YES ☐ NO ☐ UNKNOWN
8 RACE (CHECK ALL THAT APPLY): ☐ BLACK ☐ ASIAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ AMERICAN INDIAN ☐ UNKNOWN
9 PATIENT'S COUNTRY OF ORIGIN
10 DATE ARRIVED IN USA
11 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)
12 COUNTY OF RESIDENCE: Cole (5)
13 TELEPHONE NUMBER
14 PREGNANT: ☐ YES (IF YES NUMBER OF WEEKS _____) ☐ NO ☐ UNKNOWN
15 PARENT OR GUARDIAN
16 RECENT TRAVEL OUTSIDE OF MISSOURI OR USA: ☐ YES ☐ NO IF YES, WHERE
17 DATE OF RETURN
18 OCCUPATION
19 SCHOOL/DAY CARE/WORKPLACE ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)
20 WORK TELEPHONE NUMBER (6)
OTHER ASSOCIATED CASES ☐ YES ☐ NO ☐ UNKNOWN
IS REPORT PART OF AN OUTBREAK ☐ YES ☐ NO ☐ UNKNOWN
22 TYPE OF COMPLAINT/OUTBREAK: ☐ FOODBORNE ☐ WATERBORNE ☐ OTHER (SPECIFY)
23 WAS PATIENT HOSPITALIZED: ☐ YES ☐ NO ☐ UNKNOWN
24 PATIENT RESIDE IN NURSING HOME: ☐ YES ☐ NO ☐ UNKNOWN
25 PATIENT DIED OF THIS ILLNESS: ☐ YES ☐ NO ☐ UNKNOWN
26 CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):

	PATIENT			HHLD MEMBER		
	YES	NO	UNK	YES	NO	UNK
IS A FOOD HANDLER						
ATTENDS OR WORKS AT A CHILD OR ADULT DAY CARE CENTER						
IS A HEALTH CARE WORKER						

27 NAME OF HOSPITAL/NURSING HOME
28 HOSPITAL/NURSING HOME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)
29 REPORTER NAME: Main Street Urgent Care (7)
30 TELEPHONE NUMBER
31 REPORTER ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE): 555 Main Street, Missouri City, MO 65101
32 TYPE OF REPORTER/SUBMITTER: ☐ PHYSICIAN ☒ OUTPATIENT CLINIC ☐ PUBLIC HEALTH CLINIC ☐ HOSPITAL ☐ LABORATORY ☐ SCHOOL ☐ OTHER
33 ATTENDING PHYSICIAN/CLINIC NAME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)
34 TELEPHONE NUMBER

35 DISEASE NAME(S): Varicella (8)
36 ONSET DATE(S)
37 DIAGNOSIS DATE(S)
38 DISEASE STAGE/ RISK FACTOR
39 PREVIOUS DISEASE/STAGE
40 PREVIOUS DISEASE DATE(S)

41 - DIAGNOSTICS

TEST DATE (MO/DAY/YR) (9)	TYPE (10)	SPECIMEN TYPE	COLLECTION DATE (MO/DAY/YR)	QUALITATIVE/ QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (INCLUDE STREET OR RFD, CITY, STATE, ZIP CODE)
07/27/03	Documented					

42 - TREATMENTS

TREATED (Y/N/UNK)	REASON NOT TREATED	TYPE OF TREATMENT	DRUG	DOSAGE	TREATMENT DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS TREATMENT	PREVIOUS LOCATION (LIST CITY, STATE)

43 - SYMPTOMS

SYMPTOM (IF APPLICABLE) (11)	SYMPTOM SITE (IF APPLICABLE)	SYMPTOM ONSET DATE (MO/DAY/YR)	SYMPTOM DURATION (IN DAYS)
<50 Lesions			

44 COMMENTS (12)
(Not necessary, but if you choose to provide.)

MO 580-0779N (9-01) (INSTRUCTIONS ON REVERSE SIDE OF FORM) CD-1

Vaccination Status (9 – 10)

Test Date (9) – If Vaccination Status is:
Documented – enter date vaccination administered
Self Recall – enter date vaccinated as recalled by patient/parent

Type of Test (10) – Capture date reference here:
Documented – Shot record available
Self-Recall – Patient/Parent recalls vaccination given April of 2002
Childhood – Patient was given vaccination when child but does not remember year.
Never Vaccinated – No date will be needed

(11) Severity of Illness

Symptoms (11) – Enter applicable category here.

<50 Lesions – able to count lesions in 30 seconds
50 – 249 Lesions – hand can be placed between lesions without touching lesion
250 – 500 Lesions – hand *cannot* be placed between lesions without touching lesion
>500 Lesions – lesions clumped so closely together that normal skin can hardly be seen

(12) Narratives

Optional use. May be used to document anything else regarding case.