VPD-22
Revised July 2017

Varicella Reporting and Investigation Form

Complete in addition to the Notification of Infectious Disease Form (EPI-1). In the event of an outbreak additional forms and specimen collection are required for testing, a VIDOH-EPID staff will coordinate additional paperwork and investigation.

Patient Information

Source of Information: ☐ Private Physician ☐ Private Laboratory ☐ Hospital ☐ Clinic ☐ School

Today's Date: (mm/dd/yyyy)

Island: ☐ St. Croix ☐ St. John ☐ St. Thomas ☐ Water Island

Reporting Person | Reporting Address | Reporting Phone (______) ______ - _________ extension _______

Parent/Guardian (if applicable):

Patient Name (Last) | **(First)** | **(MI)** | Telephone: (_____) ____ - _______

Address (indicate ESTATE) | City | State | Zip Code | Country

Date of Birth (mm/dd/yyyy) | Age | **Gender:** ☐ Male ☐ Female | **Ethnicity:** ☐ Hispanic ☐ Not Hispanic | **Race:** ☐ Black ☐ White ☐ Asian ☐ Unknown ☐ Other:

Laboratory Information

1. **Status:** ☐ Probable Case ☐ Confirmed Case
2. **Diagnostic Criteria:** ☐ Symptoms ☐ Laboratory
3. **How was the information obtained?** ☐ Face-to-face visit ☐ Phone call with case or parent ☐ Other, specify:
4. **Types of specimen collected:** ☐ Vesicular swab ☐ Maculopapular scraping ☐ Crusts/scabs ☐ Buccal swab ☐ Other, specify:

Clinical

Date of Rash Onset: _____________________ (mm/dd/yyyy)

Where did the rash first appear?
☐ Face/head ☐ Trunk/torso ☐ Extremities
☐ Other, specify:

Distribution
☐ Face/head ☐ Inside mouth
☐ Trunk/abdomen/torso ☐ Arms
☐ Palms of hands ☐ Legs
☐ Soles of feet
☐ Other, specify:

Area where lesions are more concentrated:

Hospitalized? ☐ Yes ☐ No
Date admitted (mm/dd/yyyy):
Date discharged (mm/dd/yyyy):

Pregnant? ☐ Yes, EDD: ☐ No ☐ Unknown

Total # of lesions: ☐ < 50 ☐ 50-249 ☐ 250-500 ☐ > 500

Rash type:

Mostly macular/papular?	☐ Yes	☐ No	☐ Unknown
Mostly vesicular?	☐ Yes	☐ No	☐ Unknown
Hemorrhagic?	☐ Yes	☐ No	☐ Unknown
Itchy?	☐ Yes	☐ No	☐ Unknown
Scabs?	☐ Yes	☐ No	☐ Unknown
Crops/waves?	☐ Yes	☐ No	☐ Unknown
Fever?	☐ Yes If yes, onset date (mm/dd/yyyy):	☐ No	☐ Unknown
Immunocompromised?	☐ Yes	☐ No	☐ Unknown
Hospitalized?	☐ Yes	☐ No	☐ Unknown
Died?	☐ Yes If yes, date of death (mm/dd/yyyy):	☐ No	☐ Unknown

Vaccine History

Has previously received varicella vaccine? ☐ Yes ☐ No ☐ Unknown

Vaccine #1 date (mm/dd/yyyy): ____________________
Vaccine #1 Type: ____________________
Vaccine #1 Manufacturer: ____________________
Vaccine #1 Lot #: ____________________

Vaccine #2 date (mm/dd/yyyy): ____________________
Vaccine #2 Type: ____________________
Vaccine #2 Manufacturer: ____________________
Vaccine #2 Lot #: ____________________

Epidemiological

Attends/teaches school/daycare or is associated with healthcare worker or group living? ☐ Yes ☐ No ☐ Unknown

Occupation: ____________________ Facility Name: ____________________

Grade/Room and Teacher: ____________________ Facility Phone: ____________________

How long have you lived in the USVI? ____________________ **Country of birth:** ____________________

Prior to onset of rash, was this case epi-linked to another confirmed or probable case? ☐ Yes ☐ No ☐ Unknown