MONTANA DPHHS
VARICELLA REPORTING AND CASE INVESTIGATION FORM

Report Status

Date reported: _____/_____/_____ **Reported by:** _____ **Phone Number:** _____

Reporting Site/Clinic: _____ **Town/City:** _____

Reporting Source Type:
☐ **School** ☐ **Daycare** ☐ **Physician** ☐ **Parent** ☐ **Health Dept.** ☐ **Other:** _____

Demographic Information

Race _____ **Hispanic** ☐ **Yes** ☐ **No** **Sex:** ☐ **Male** ☐ **Female**

Patient Name: _____ **Date of Birth:** _____/_____/_____ (mm dd yyyy) **Age:** _____

Address: _____ **City:** _____ **Zip Code:** _____ **Home Phone:** _____

***Parent/Guardian Name (optional):** _____ **Parent/Guardian Work Phone (optional):** _____

Case Attends: ☐ **School** ☐ **Daycare** ☐ **Work** ☐ **College** ☐ **Other:** _____

Name of Institution : _____ **City:** _____

*Report fields in shaded boxes - optional

Clinical Data

☐ **Probable** ☐ **Confirmed**

Rash Onset: ____/____/____ (mm dd yyyy) **Number of Lesions:** ☐ **Less than Avg (<50)** ☐ **Avg (50-250)** ☐ **Greater than Avg (>250)**

Lab Confirmed? ☐ **Yes** ☐ **No** ☐ **Unknown**
Test type: ☐ **DFA** ☐ **IgM** ☐ **IgG** ☐ **PCR** ☐ **Other:** _____ **Result:** _____

Disease History:
Chickenpox?: ☐ **Yes** ☐ **No** ☐ **Unknown** **Age when chickenpox occurred:** _____

Vaccination History: ☐ **Yes** ☐ **No** ☐ **Unknown**
If yes, Date Administered: **VZV Dose 1:** _____/____/_____ **VZV Dose 2:** _____/_____/_____

Hospitalized?: ☐ **Yes** ☐ **No** **If yes, Hospital Name:** _____ **Days Hospitalized:** _____

Physician's Name _____**Physician's Address** _____

Administrative Rules of Montana 37.114.514 (http://arm.sos.mt.gov/37/37-28771.htm)

1. A confirmed or probable case must be excluded from school, medical offices, and other public places and instructed to avoid contact with individuals who are susceptible until vesicles become dry.
2. Susceptible contacts should be evaluated and counseled regarding the advisability of and recommendations for post-exposure vaccination.
3. Susceptible contacts ineligible for immunization and determined to be at high-risk for complications should be promptly evaluated for consideration whether varicella-zoster immune globulin (VZIG) administration should occur.