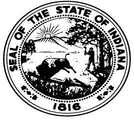

VARICELLA (CHICKENPOX) CASE INVESTIGATION

State Form 53800 (11-08)
Indiana State Department of Health

See reverse for instructions.

Section 1: Demographic Information

Patient's Name:	*Last Name*	*First Name*	*MI*
Address:	*Street Address (number and street)*	*City* / *State*	*ZIP code*
County	*Telephone Number* ( )	*Parent's or Guardian's Name (if applicable)*	
Date of Birth:	*Month/Day/Year (XX/XX/XXXX)*	*Age:* __________ ☐ Days ☐ Months	☐ Years
Race:	☐ Asian ☐ Black or African American ☐ White	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other/Multiracial	☐ Unknown
Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	Sex:	☐ Male ☐ Female ☐ Unknown
Name of Employer/School/Daycare:	*Name*		
Address of Employer/School/Daycare:	*Address*		

Section 2: Clinical Information

Date of Rash Onset:	*Month/Day/Year (XX/XX/XXXX)*	Number of Lesions:*	☐ < 50 ☐ 50 – 249 ☐ 250 – 499 ☐ > 500
Was case diagnosed by a healthcare provider?	☐ Yes ☐ Unknown ☐ No	*Name of Provider*	*Provider telephone number* ( )
Was the patient hospitalized?	☐ Yes ☐ No	*Hospital Name*	*Admission Date (XX/XX/XXXX)*
Did the patient die from varicella or complications (including secondary infection) associated with varicella?	☐ Yes ☐ No		*Date of Death (XX/XX/XXXX)*

Section 3: Laboratory

Was laboratory testing done for varicella?	☐ Yes ☐ No ☐ Unknown						
Acute Serology:	*Collection Date (XX/XX/XXXX)*	IgM Result:	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done	IgG Result:	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done		
Convalescent Serology:	*Collection Date (XX/XX/XXXX)*	☐ Significant rise in IgG (four-fold increase) ☐ No significant rise in IgG					
PCR:	*Collection Date (XX/XX/XXXX)*	PCR Results:	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done	Culture:	*Collection Date (XX/XX/XXXX)*	Culture Results:	☐ Positive ☐ Negative ☐ Indeterminate ☐ Not Done

Section 4: Vaccination History

Did the patient receive varicella vaccine on or after the first birthday? ☐ Yes ☐ No ☐ Unknown ☐ N/A

If yes, enter the vaccination history:	*Vaccination Date XX/XX/XXXX*	*Vaccine Type*	*Manufacturer*	*Lot Number*

Investigator Information

Investigator Name:		Agency:	
Telephone number:	( )	Date *(XX/XX/XXXX)*:	

INSTRUCTIONS FOR COMPLETING
STATE FORM 53800, VARICELLA (CHICKENPOX) CASE INVESTIGATION

This form is to be utilized for the investigation of individual cases of varicella by local health department staff pursuant to 410 IAC 1-2.3-110. This form is to be completed for *each* individual case of varicella.

This form contains confidential information per 410 IAC 1-2.3.

1. Print all information clearly and neatly.
2. Provide all information available and attach any supporting documents, including lab reports when applicable.
3. Upon completion, return the form via fax (preferably) or mail to:

Indiana State Department of Health
Surveillance and Investigation
2 North Meridian Street
Section 5K 99
Indianapolis, IN 46204
Fax: (317) 234-2812

* Number of lesions can be determined using the following guidance:
Fewer than 50: easily counted in 30 seconds
50 – 249: patient's hand can be placed on body without touching a lesion
250 – 499: patient's hand cannot be placed on body without touching a lesion
500 or more: cannot observe normal skin