ICMR-National Institute of Virology, Pune 411001
Varicella Case Investigation Form

Name of Patient:

Address:

Date of birth: **Age:** **Sex:**

CLINICAL DATA

Symptoms and signs

Date of onset: **Fever: Yes/No…….days**

Cough: Yes/No…….days **Cold (coryza): Yes/No…….days**

Conjunctivitis: Yes/No…….days **Lymphadenopathy: Yes/No…….days**

Skin Rash: Yes/No…….days **Type of skin rash: macular/popular/maculopapular**

Spread of rash: **Other Important Clinical Features:**

Complications

Varicella Vaccination Status

Yes/No **Varicella: one dose/ two doses**

Date/s of Immunization: **Place of Immunization:**

Name of Clinician/GP: **Vaccine details (batch, make etc):**

Contact History (Within 3 weeks prior to onset of illness)

Family Contacts: **Neighborhood contacts:**

Visit to crowded place:

Patient hospitalization

Hospitalization: Yes/No **Date:** **Treatment given (if any):**

Hospital name: **Hospital No:** **Ward No:**

Date of discharge/transfer/death:

Outcome of case: Cured/transferred/died/not known

CLINICAL SAMPLES TAKEN FOR LABORATORY INVESTIGATION

Blood/Serum/ Cerebrospinal fluid (CSF):

Throat /Oral swabs: **Urine:** **Skin swab:** **Other:**

Name of Epidemiologist: **Date:** **Place:**

Contact details **Tel:** **Mob:** **Email**