

WEEKLY REPORTING FORM

Influenza-Like Illness / Gastro-Intestinal Illness and Chickenpox

Please fax a copy of this form by county

TO

Branch County: CD Nurse-517-278-2923 **Hillsdale County:** CD Nurse – 517-437-0166
St. Joseph County: CD Nurse – 269-273-2161

REPORTS ARE NEEDED AT THE C.H.A. EACH FRIDAY BEFORE 10 AM!

Health Care Providers play an essential role in reporting Communicable Disease in the community. According to the State of Michigan Public Health Code (Public Act 368, of 1978 as amended), **the local Health Department shall be notified of the occurrence of reportable communicable disease--WITHOUT DELAY.** Timely reporting is important to identify disease trends within communities and help prevent the spread of illnesses.

Week Ending Friday ____/____/200____	Practice Name _____
Date: _____	Submitted by: _____ Telephone: _____

	Number of Cases	Definition
Influenza Like Illness (Respiratory Flu)		Any patient <i>with fever AND any of the following symptoms</i> : sore throat, cough, generalized aching in the back or limb muscles. <i>*Vomiting and diarrhea alone are NOT respiratory flu *</i>
Gastrointestinal Illness ('Stomach Flu')		Any patient with vomiting and/or diarrhea for 24 to 48 hours (24-hour flu, winter vomiting disease or Norovirus)
Unknown Influenza ('Flu')		

NOTE: 9/05 REPORTING CHANGE – Report INDIVIDUAL Varicella (Chicken Pox)

Use the Varicella Reporting Form on the back side to fax a case report IMMEDIATELY to our CHA site

(OVER)

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY

CHICKENPOX (VARICELLA) CASE REPORT

Date _____

Patient Name: _____			
Parent/Caregiver:(required if under 18) _____			
Address: _____			
Phone: _____		Alternate Phone: _____	
		School: _____	
Sex: M F	Age: _____	Date of Birth _____	Grade: _____
Race: <input type="checkbox"/> Caucasian		<input type="checkbox"/> African American	
<input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> Asian	
<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other (Specify) _____			
Ethnicity: <input type="checkbox"/> Hispanic/ Latino		<input type="checkbox"/> Not Hispanic/Latino	
		<input type="checkbox"/> Unknown	
Diagnosed by _____		Date Diagnosed _____	

Varicella Vaccination History

Has patient received varicella vaccine? YES NO UNKNOWN

If YES, date the vaccine was given _____

Severity of illness (as reflected by approximate number of lesions):

- Fewer than 50 (easily counted in 30 seconds)
- 50-249 (patient's hand can be placed somewhere on body without touching a lesion)
- 250-499 (patient's hand cannot be placed on body without touching one or more lesions)
- 500 or more (cannot observe normal skin)

Person Reporting _____ **Office** _____
Phone Number _____

OTHER NEW ILLNESSES? [Check(✓) OF (#) if within reporting week. Someone MAY call for information]

AIDS	HEPATITIS A	PERTUSSIS
AMEBIASIS	HEPATITIS B – ACUTE	PINK EYE
ANIMAL BITE	HEPATITIS B- CHRONIC	SALMONELLOSIS
BLASTOMYCOSIS	HEPATITIS C – ACUTE	SCABIES
CAMPYLOBACTER	HEPATITIS C – CHRONIC	SHIGELLOSIS
CHLAMYDIA	HISTOPLASMOSIS	STREP PNEUMONIA INV
CRYPTOSPORIDIOSIS	IMPETIGO	STAPH INFECTIONS
ENCEPHALITIS-PRIMARY	KAWASAKI	STREP INVASIVE GP A
ENCEPHALITIS-ST. LOUIS	LEGIONELLOSIS	STREP THROAT
E COLI 0157	LYME DISEASE	SYPHILIS
GIARDIASIS	MALARIA	TUBERCULOSIS
GONORRHEA	MENINGITIS-ASEPTIC	WEST NILE VIRUS
GUILLAIN BARRE'	MENINGITIS-BACTERIAL	
HEAD LICE	MONONUCLEOSIS	

For Agency Only:

Date Report entered MDSS _____ **Date to Coordinator** _____ **Initials** _____