

## Varicella MOHSIS Entry LPHA Guide

### Search/Add Client

Client Name (1)

Client Date of Birth and  
Gender (2) (Add Party Screen)

### Search /Add Locator

For Varicella Reports not  
resulting in death,  
associate address of  
LPHA.

### Case Notification

Date Received by LHA (3)

Agency Type (4) Select  
Other

Notifier (5) Although  
Reporter shown in this  
field, search for and select  
LHA name so jurisdiction  
will be associated  
correctly

Date of Report (6)

Disease (7) Varicella  
entered

### Background Information

Other Cases (8)

**No information needed on  
Risk Information, to go Tests  
Tab**

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES		REPORT TO LOCAL PUBLIC HEALTH AGENCY						
DISEASE CASE REPORT								
1 NAME (LAST, FIRST, MI.) <b>Person, Sick E.</b>		2 DATE OF REPORT 04-01-20 <b>06</b>	3 DATE RECEIVED BY LOCAL HEALTH AGENCY <b>03</b>					
4 GENDER <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		5 DATE OF BIRTH 08-2-1959	6 AGE	7 ETHNICITY <input type="checkbox"/> HISPANIC <input type="checkbox"/> NO <input type="checkbox"/> AMERICAN INDIAN				
8 RACE (CHECK ALL THAT APPLY) <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> UNKNOWN		9 PATIENT'S COUNTRY OF ORIGIN		10 DATE ARRIVED IN USA				
11 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)			12 COUNTY OF RESIDENCE		13 TELEPHONE NUMBER			
14 PRISONER? <input type="checkbox"/> YES IF YES NUMBER OF WEEKS _____ <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		15 PARENT OR GUARDIAN		16 RECENT TRAVEL OUTSIDE OF MISSOURI OR USA <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHERE				
17 OCCUPATION		18 SCHOOL/DAY CARE/WORKPLACE		19 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)				
20 WORK TELEPHONE NUMBER		21 OTHER ASSOCIATED CASES <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		22 TYPE OF COMPLAINT/OUTBREAK <input type="checkbox"/> FOODBORNE <input type="checkbox"/> WATERBORNE <input type="checkbox"/> OTHER (SPECIFY)				
23 WAS PATIENT HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		24 PATIENT RESIDE IN NURSING HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		25 PATIENT DIED OF THIS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN				
27 NAME OF HOSPITAL/NURSING HOME		26 CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHELD)		PATIENT				
28 HOSPITAL/NURSING HOME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)		29 IS A FOOD HANDLER		HHELD MEMBER				
26 REPORTER NAME Main Street Urgent Care		30 TELEPHONE NUMBER		31 IS A HEALTH CARE WORKER				
31 REPORTER ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE) 565 Main Street, Missouri City, MO 65101		32 TYPE OF REPORTER/WRITER <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OUTPATIENT CLINIC <input type="checkbox"/> PUBLIC HEALTH <input type="checkbox"/> HOSPITAL <input type="checkbox"/> LABORATORY <input type="checkbox"/> SCHOOL <input type="checkbox"/> OTHER		34 TELEPHONE NUMBER				
33 ATTENDING PHYSICIAN/CLINIC NAME		34 ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE)		35 TELEPHONE NUMBER				
36 DISEASE NAME(S) Varicella		37 ONSET DATE(S)	38 DIAGNOSIS DATE(S)	39 DISEASE STAGE/ RISK FACTOR	40 PREVIOUS DISEASE DATE(S)			
<b>41 - DIAGNOSTICS</b>								
TEST DATE (MO/DY/YR)	TYPE OF TEST	SPECIMEN TYPE	COLLECTOR/REF (MO/INITIALS)	QUALITATIVE QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (INCLUDE STREET OR RFD, CITY, STATE, ZIP CODE)		
07/27/03	Documented							
<b>42 - TREATMENTS</b>								
TREATED (Y/N/UNK)	REASON NOT TREATED	TYPE OF TREATMENT	DRUG	DOSAGE	TREATMENT DATE (MO/DAY/YR)	TREATMENT DURATION (DAYS)	PREVIOUS TREATMENT	PREVIOUS LOCATION (CITY/STATE)
SYMPTOM (IF APPLICABLE)		SYMPTOM SITE (IF APPLICABLE)		SYMPTOM ONSET DATE (MO/DAY/YR)		SYMPTOM DURATION (IN DAYS)		
<50 Lesions								
<b>43 - SYMPTOMS</b>								
15 COMMENTS (Not necessary, only if you choose to provide.)								

### Tests

#### • Vaccination Status 9-11

Test Type (9) Vaccination  
Status

Results (10) – Choose:  
Documented  
Self-Recall  
Childhood  
Never Vaccinated

Test Date (11) – use value  
for Documented or Self-  
Recall or Date of Report (6)  
date for Childhood or Never  
Vaccinated

#### • Severity of Illness 12-14

Test Type (12) Severity of  
Illness selected

Results (13) – Choose:  
<50 Lesions  
50 – 249 Lesions  
250 – 500 Lesions  
>500 Lesions

Test Date (14) – Will be  
Date of Report (6) date

**No information needed for  
Treatments or Symptoms Tabs**

### Narratives

Comments/Narratives (15)