



**NC Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

MPOX

CONFIDENTIAL COMMUNICABLE DISEASE REPORT – PART 2

ATTENTION Local Health Department Staff. Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias
Birthdate (mm/dd/yyyy): / /			SSN:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M to F <input type="checkbox"/> F to M
Patient Street Address		City	State	ZIP	County
Occupation		Employer Name	Business or industry		
Phone () -					

NC EDSS LAB RESULTS – Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name –City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? Y N U
 If yes, earliest (1st) symptom onset date (mm/dd/yyyy): / /

Fever Y N U
 Yes, subjective No
 Yes, measured Unknown
 Highest measured temperature _____
 Fever onset date (mm/dd/yyyy): / /

Fatigue or malaise or weakness Y N U

Sweats (diaphoresis) Y N U
 Night sweats Y N U

Chills or rigors Y N U

Swollen lymph nodes (lymphadenopathy or lymphadenitis) Y N U
 Distribution
 Cervical (neck), right Cervical (neck), left
 Axillary (armpit), right Axillary (armpit), left
 Inguinal (groin), right Inguinal (groin), left

Tenderness Tender Non-tender

Headache Y N U

Encephalopathy Y N U

Muscle Aches / pains (myalgias) Y N U

Skin rash Y N U
 Onset date (mm/dd/yyyy): / /
 Observed by health care provider Y N U
 Duration: _____
 Unit: Hours Days Weeks

Appearance (select all that apply)
 Macular Pustular Bullous Unknown
 Papular Vesicular Petechial

Further appearance of rash
 Discrete Confluent Unknown

Date last scab fell off (mm/dd/yyyy): / /

Total number of lesions
 1-9 10-49 50-99 ≥100

Specify body region(s) where the rash occurred (Select all that apply)
 Pelvis/groin/buttocks/hip Arms
 Face Palm of hands
 Head Soles of feet
 Mouth, lips, or oral mucosa Genitals
 Eyes or eyelids Perianal
 Neck Other
 Trunk Unknown

Conjunctivitis Y N U

Corneal ulcer(s) or keratitis Y N U

Runny nose and/or teary eyes (coryza) Y N U

Sore throat Y N U

Airway compromised due to lymphadenitis Y N U

Cough Y N U

Shortness of breath / difficulty breathing / respiratory distress Y N U

Nausea Y N U

Vomiting Y N U

Abdominal pain or cramps Y N U

Tenesmus (urgency to defecate) Y N U

Rectal pain Y N U

Rectal bleeding Y N U

Pus or blood in stools Y N U

Other symptoms, signs, clinical findings, or complications consistent with this illness? Y N U
 If yes, please specify _____

PREDISPOSING CONDITIONS/ COMORBID CONDITIONS

Any immunosuppressive conditions? Y N U
 If yes, please specify _____

Injury/Wound/Break in skin Y N U
 Anatomic site _____
 Circumstances _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias
Birthdate (mm/dd/yyyy): / /			SSN:		

PREGNANCY	HEALTHCARE INFORMATION	CLINICAL OUTCOMES
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Is the patient currently pregnant? .. Y N U

Estimated delivery date (mm/dd/yyyy): / /

Actual delivery date (mm/dd/yyyy): / /

Number of weeks gestation at onset of illness _____

Trimester of gestation at onset of illness

First Second Third Unknown

Has the patient been pregnant in the past 12 months? Y N U

INFANT BIRTH DETAILS

If patient was pregnant during the 21 days prior to onset of symptoms, give infant birth details:

Where was the child born?

Hospital Other

Home Unknown

Hospital or facility where child was born:

Infant gestational age at birth:

Full term Premature Unknown

Birth weight _____

Number of weeks gestation _____

Vital status:

Born alive and still alive

Born alive and then died

Stillborn

Fetal death/spontaneous abortion

Unknown

Date of child death (mm/dd/yyyy): / /

Give cause(s) of death from death certificate:

Was an autopsy performed? ... Y N U

If yes, give final pathological diagnosis:

TREATMENT

Did this patient receive anti-orthopoxviral treatment? Y N U

Specify antiviral name:

Brincidofovir (CMX001, Tembexa)

Cidofovir (Vistide)

Tecovirimat (TPOXX, ST-246)

Other, specify:

Date antiviral treatment began(mm/dd/yyyy): / /

Treatment Notes:

Was the patient hospitalized for this illness > 24 hours? Y N U

Hospital name: _____

City, State: _____, _____

Hospital contact name: _____

Phone: (____) _____ - _____

Admit date (mm/dd/yyyy): / /

Discharge date (mm/dd/yyyy): / /

Medical record number for this hospitalization:

ISOLATION/QUARANTINE/CONTROL MEASURES

Restriction to movement or freedom of action (i.e. work, child care, school, etc.)? Y N

Check all that apply:

Work Sexual behavior

Child care Blood and body fluid

School

Other: _____

Date control measure issued(mm/dd/yyyy): / /

Date control measure ended(mm/dd/yyyy): / /

Was patient compliant with control measures?..... Y N U

Did the local health director or designee implement additional control measures? Y N

If yes, please specify _____

Were written isolation orders issued? Y N U

If yes, where was the patient isolated? _____

Date isolation started (mm/dd/yyyy): / /

Date isolation ended (mm/dd/yyyy): / /

Was patient compliant with isolation? Y N U

Were written quarantine orders issued? Y N U

If yes, where was the patient quarantined? _____

Date quarantine started (mm/dd/yyyy): / /

Date quarantine ended (mm/dd/yyyy): / /

Basis for quarantine:

Voluntary

Mandatory by order of state or local health dept.

Was patient compliant with quarantine? Y N U

Comments on isolation and quarantine only:

Discharge/Final diagnosis: _____

Clinical outcome:

Survived Died

Died from this illness Y N U

Patient died in NC Y N U

County of death: _____

Autopsy performed Y N U

Patient autopsied in NC Y N U

County of autopsy: _____

Date of death (mm/dd/yyyy): / /

Source of death information (select all that apply):

Death certificate

Autopsy report final conclusions

Hospital/discharge physician summary

Other

TRAVEL/IMMIGRATION

The patient is:

Resident of NC

Resident of another state or US territory

Foreign Visitor Recent Immigrant

Refugee Foreign Adoptee

None of the above

In the 21 days prior to illness onset, did the patient have any travel history? Y N U

List travel dates (mm/dd/yyyy) and destinations:

From / / to / /

Mode(s) of transportation (check all that apply):

Airplane Bus / taxi / shuttle

Ship / boat / ferry Train / subway

Automobile / motorcycle On foot

Other, specify:

Additional Travel/Residency information:

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CHILD CARE/SCHOOL/COLLEGE	HEALTH CARE RISK FACILITY
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Does patient attend child care?... Y N U
 In what county is child care center located: _____
 Name of child care provider: _____

Is patient a child care worker/volunteer? Y N U
 In what county is child care center located: _____
 Name of child care provider: _____

Is patient a student? Y N U
 In what county is school located: _____
 Type of school:
 NC public school (preK-12)
 NC private school (preK-12)
 Other school (preK-12)
 Community College
 College/University
 Other academic institution (trade school, professional)
 Name of school: _____

Is patient a school worker/volunteer? Y N U
 In what county is school located: _____
 Type of school:
 NC public school (preK-12)
 NC private school (preK-12)
 Other school (preK-12)
 Community College
 College/University
 Other academic institution (trade school, professional)
 Name of school: _____

During the period of interest, has the patient attended any social gatherings or crowded settings?..... Y N U
 If yes, please specify setting(s): _____

SEXUAL RISK
During the period of interest, has the patient had sexual contact with a FEMALE? Y N U
 Specify number of female sexual partners during period of interest: _____

During the period of interest, has the patient had sexual contact with a MALE? Y N U
 Specify number of male sexual partners during period of interest: _____

During the period of interest, has the patient had sexual contact with a PERSON OF OTHER GENDER IDENTITY? Y N U
 Specify number of partners of other gender identity during period of interest: _____

During the period of interest, did the patient meet sexual partners on the Internet/apps? Y N U
 Specify sites the has patient used: _____

 Total number of internet sex partners: _____

During the period of interest, did the patient meet a partner at a bar or a club?..... Y N U
During the period of interest, did the patient have sex at a sex party? Y N U
During the period of interest, did the patient trade sex for drugs or money? Y N U

In the 21 days prior to illness onset, did the patient have any of the following health care exposures?
 Emergency Department (not hospitalized)
 Hospitalized
 Outpatient facility – patient (e.g. urgent care, clinic, physician office)
 Visitor to health care setting
 Worked in healthcare or clinical laboratory setting
 No
 Unknown
 Visit / admit date (mm/dd/yyyy): / /
 Facility name: _____

Health care exposure notes:

BEHAVIORAL RISK AND CONGREGATE LIVING

CONGREGATE LIVING
During the period of interest, did the patient stay in any congregate living facilities or other locations that were not their primary residence? Y N U
 If yes, please specify facility (select all that apply):
 Correctional facility Commune
 Barracks Boarding school
 Shelter Camp
 Dormitory, sorority, fraternity
 Other, specify:
 Name of facility or intuition: _____

 Start date (mm/dd/yyyy): / /
 End date (mm/dd/yyyy): / /

SUBSTANCE USE
During the period of interest, did the patient use injection drugs? Y N U
 Indicate drug(s) used (check all that apply):
 Cocaine Methamphetamine
 Crack Stimulants
 Heroin Not specified
 Narcotics/Opioids
 Other, specify:
During the period of interest, did the patient use NON-injection drugs? Y N U
 Indicate drug(s) used (check all that apply):
 Alcohol Methamphetamine
 Marijuana Stimulants
 Cocaine Nitrates/Poppers
 Crack Erectile dysfunction medications
 Heroin Not specified
 Narcotics/Opioids Not specified
 Other, specify:

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OTHER EXPOSURE INFORMATION	ANIMAL EXPOSURE
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Does the patient know anyone else with similar symptoms?..... Y N U

If yes, please specify: _____

During the period of interest, did the patient have contact with a known mpox case (probable or confirmed)?..... Y N U

If the patient had contact with a known mpox case:

What type of contact?

Household contact

Community-associated contact

Work-associated contact

Healthcare-associated contact (patient, visitor, healthcare worker)

Sexual (e.g., vaginal, oral, or anal sex) or intimate contact (e.g., cuddling, kissing, touching partner's genitals or anus, or sharing sex toys)

Other, specify: _____

Unknown

During the period of interest, did the patient have any of the following additional risk exposures? (check all that apply)

Sports Team Participation
Specify team/affiliation: __ _____
Specify type of sport: __ _____

Pool or spa
Specify name: __ _____

Personal Care; eg. Hair salon, massage
Specify name: __ _____

Hotel / motel
Specify name: __ _____

Adult Day Care/PACE program
Specify name: __ _____

Bars, Brewery, or nightclubs
Specify name: __ _____

Gym or Fitness centers
Specify name: __ _____
Specify type of fitness activity: __ _____

Day Camp
Specify name: __ _____

Work (if any of these selected risks are work, please ensure work is also selected)
Occupation: __ _____
Employer name: __ _____
Business/Industry: __ _____

Other
Specify: __ _____

None

Unknown

Did the patient work with smallpox vaccine or other orthopox vaccine?..... Y N U

If yes, please specify and give details (notes):

Did the patient work with mpox vaccine or other orthopox vaccine?..... Y N U

If yes, please specify and give details (notes):

During the period of interest, did the patient have exposure to household pets or other animals (includes animal tissues, animal products, or animal excreta)?..... Y N U

Did the patient have contact with household pets?..... Y N U

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder / wholesaler / distributor?..... Y N U

Did the patient work in animal importation?..... Y N U

Was the patient exposed to wild animals?..... Y N U

Did the patient hunt or trap animals?..... Y N U

Did patient skin / eviscerate (gut) wild animal or contact with wild animal carcass?..... Y N U

Did the patient necropsy animals?..... Y N U

Did patient have contact with commercial animal products (i.e. wool, hair, hides, fur, raw / smoked meat, bones, bone meal)?..... Y N U

Did the patient work at or visit a fair with livestock or a petting zoo?..... Y N U

Did the patient work at or visit a zoo, zoological park, or aquarium?..... Y N U

Did the patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory?..... Y N U

Specify animal(s) and give details:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias
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CASE INTERVIEWS / INVESTIGATIONS	OUTBREAK
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Was the patient interviewed?..... Y N U

Date of interview (mm/dd/yyyy): / /

Were interviews conducted with others?..... Y N U

Who was interviewed?

<input type="checkbox"/> Employer / supervisor / co-worker	<input type="checkbox"/> Household contact / roommate
<input type="checkbox"/> Friend / neighbor	<input type="checkbox"/> Parent
<input type="checkbox"/> Guardian	<input type="checkbox"/> Other, specify:

Were health care providers consulted?..... Y N U

Who was consulted?

<input type="checkbox"/> Infectious disease physician	<input type="checkbox"/> Physician
<input type="checkbox"/> PA / FNP	<input type="checkbox"/> Other, specify:

Medical record(s) reviewed (including telephone review with provider/office staff)?..... Y N U

Notes on medical record verification:

Is the patient part of an outbreak for this disease?..... Y N U

VACCINE INFORMATION

Has patient / contact every received vaccine related to this disease?..... Y N U

If yes, number of doses received: _ _ _

Vaccine type

<input type="checkbox"/> ACAM2000
<input type="checkbox"/> DryVax (prior to 2008)
<input type="checkbox"/> JYNNEOS
<input type="checkbox"/> Other vaccinia (smallpox) vaccine
<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Unknown vaccine or immune globulin

Date of administration (mm/dd/yyyy): / /

Vaccine date unknown Y N U

Source of vaccine information

<input type="checkbox"/> Patient's or parent's verbal report	<input type="checkbox"/> Patient vaccine record
<input type="checkbox"/> Physician	<input type="checkbox"/> School record
<input type="checkbox"/> Medical Record	<input type="checkbox"/> NCIR Record
<input type="checkbox"/> Certificate of immunization record	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other, specify:	

Reason for vaccination

<input type="checkbox"/> Pre-exposure
<input type="checkbox"/> Post-exposure
<input type="checkbox"/> Routine pre-exposure
<input type="checkbox"/> Unknown

Notes (including adverse reactions, etc.):
