North Carolina 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.

VACCINIA
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 70

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease. 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

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, 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
Chills or rigors ☐Y ☐N ☐U
Shock ☐Y ☐N ☐U
Was systolic BP <90mm Hg ☐Y ☐N ☐U
Shock was: ☐Septic ☐Hypovolemic
Swollen lymph nodes (lymphadenopathy or lymphadenitis) ☐Y ☐N ☐U
Distribution:
☐Generalized ☐Regional ☐Unilateral
☐Bilateral ☐Unknown
Location
☐Preauricular ☐Inguinal
☐Cervical ☐Femoral
☐Axillary ☐Other_____
Tenderness
☐Tender ☐Non-tender
Altered mental status ☐Y ☐N ☐U
Patient displayed (select all that apply):
☐Confusion ☐Agitation
☐Delirium ☐Drowsiness
☐Disorientation ☐Hallucinations
☐Coma ☐Lethargy
Headache ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____
Type: ☐Intermittent ☐Constant
Stiff neck ☐Y ☐N ☐U
Eyes sensitive to light (photophobia) ☐Y ☐N ☐U
Meningitis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____

Elevated CSF protein ☐Y ☐N ☐U
Elevated CSF cell count ☐Y ☐N ☐U
Encephalomyelitis/ meningoencephalitis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____
Encephalopathy ☐Y ☐N ☐U
Seizures/convulsions ☐Y ☐N ☐U
Specify:
☐New onset
☐Exacerbation of underlying seizure disorder
☐Other_____
☐Unknown
Muscle weakness (paresis) ☐Y ☐N ☐U
Specify: ☐Localized ☐Generalized
Muscle paralysis ☐Y ☐N ☐U
Acute flaccid paralysis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____
☐Asymmetric ☐Symmetric
☐Ascending ☐Descending
Respiratory paralysis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____
Skin rash ☐Y ☐N ☐U
Onset date (mm/dd/yyyy)____/____/____
Observed by health care provider ☐Y ☐N ☐U
Duration_____ ☐Days ☐Weeks
Location:
☐All over the body (generalized)
☐Generalized, predominantly central/torso/back (centripetal)
☐Generalized, predominantly face/hands/feet (centrifugal)
☐Localized/focal
☐Palms and soles
Appearance (select all that apply)
☐Macular ☐Vesicular
☐Papular ☐Bullous
☐Pustular ☐Petechial
☐Unknown
Further appearance of rash:
☐Discrete ☐Confluent ☐Unknown
Skin lesions ☐Y ☐N ☐U
Describe (check all that apply)
☐Papule ☐Pustule ☐Vesicle ☐Ulcer
Abscess/infected skin lesion (pyoderma) ☐Y ☐N ☐U
Skin itching (pruritis) ☐Y ☐N ☐U
Swollen eyelids (periorbital edema) ☐Y ☐N ☐U
Conjunctivitis ☐Y ☐N ☐U
Corneal ulcer(s) or keratitis ☐Y ☐N ☐U
Myocarditis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):____/____/____
Echocardiography performed ☐Y ☐N ☐U
☐Normal
☐Abnormal, describe: _____
☐Clear ☐Purulent ☐Bloody (hemoptysis)
☐Other_____
Vomiting ☐Y ☐N ☐U
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
Specify _____
Clinical classification
☐Generalized vaccinia
☐Progressive vaccinia
☐Eczema vaccinatum
☐Fetal vaccinia
☐Ocular vaccinia
☐Postvaccinial encephalopathy or encephalomyelitis
☐Postvaccinial non-specific rash
☐Postvaccinial cardiomyopathy
☐Unknown
Notes:

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

PREDISPOSING CONDITIONS

Immunosuppressive conditions (not including HIV/AIDS) ☐Y ☐N ☐U

Specify _____

Immunoglobulin (IG) deficiency ☐Y ☐N ☐U

Autoimmune disease ☐Y ☐N ☐U

Specify:
- ☐ Systemic lupus erythematosus
- ☐ Rheumatoid arthritis
- ☐ Other

Diabetes ☐Y ☐N ☐U

Malignancy ☐Y ☐N ☐U

Lymphoma/Hodgkin's disease ☐Y ☐N ☐U

Multiple myeloma ☐Y ☐N ☐U

Leukemia ☐Y ☐N ☐U

Other malignancy (ies) ☐Y ☐N ☐U

Cardiovascular/heart disease (including congenital heart disease) ☐Y ☐N ☐U

Heart failure ☐Y ☐N ☐U

Valvular heart disease or vascular graft ☐Y ☐N ☐U

Congenital heart disease ☐Y ☐N ☐U

Other cardiovascular/heart disease ☐Y ☐N ☐U

Other underlying illness ☐Y ☐N ☐U

Specify _____

Receiving treatment or taking any medications:
- ☐ Chemotherapy
- ☐ Immunosuppressive therapy, including anti-rejection therapy
- ☐ Radiotherapy
- ☐ Systemic steroids/corticosteroids, including steroids taken by mouth or injection

Was medication taken/therapy provided within the last 30 days before this illness? ☐Y ☐N ☐U

For what medical condition? _____

_____

REASON FOR TESTING

Why was the patient tested for this condition?
- ☐ Symptomatic of disease
- ☐ Screening of asymptomatic person with reported risk factor(s)
- ☐ Exposed to organism causing this disease (asymptomatic)
- ☐ Household / close contact to a person reported with this disease
- ☐ Other, specify_____
- ☐ Unknown

TREATMENT

Did the patient receive an antiviral for this illness? ☐Y ☐N ☐U

Antiviral name _____

Date antiviral treatment began____/____/____

Time antiviral treatment began_____ ☐AM ☐PM

Number of days taken_____ ☐Unknown

Was antiviral prophylaxis given prior to illness onset? ☐Y ☐N ☐U

Number of days medication was taken_____ ☐Unknown

Has the patient ever received immune globulin? ☐Y ☐N ☐U

When was the last dose received?____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐Y ☐N

Check all that apply:
- ☐ Work
- ☐ Child care
- ☐ School
- ☐ Sexual behavior
- ☐ Blood and body fluid
- ☐ Other, specify

_____

Date control measures issued:____/____/____

Date control measures ended:____/____/____

Was patient compliant with control measures? ☐Y ☐N

Local health director or designee implement additional control measures? ☐Y ☐N

If yes, specify: _____

_____

Were written isolation orders issued? ☐Y ☐N

If yes, where was the patient isolated? _____

_____

Date isolation started: ____/____/____

Date isolation ended: ____/____/____

Was the patient compliant with isolation? ☐Y ☐N

Were written quarantine orders issued? ☐Y ☐N

If yes, where was the patient quarantined?

_____

Date quarantine started: ____/____/____

Date quarantine ended: ____/____/____

Was the patient compliant with quarantine? ☐Y ☐N

HOSPITALIZATION INFORMATION

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

Hospital name: _____

City, State:_____

Hospital contact name: _____

Telephone: (_____) _____ - _____

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

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

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____

_____

Survived? ☐Y ☐N ☐U

Died? ☐Y ☐N ☐U

Died from this illness? ☐Y ☐N ☐U

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

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ None of the above

Did patient have a travel history during the one month prior to onset of symptoms? ☐Y ☐N ☐U

List travel dates and destinations:

From _____/_____/_____ to _____/_____/_____

_____

_____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐Y ☐N ☐U

List persons and contact information:

_____

_____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐Y ☐N ☐U

Patient a child care worker or volunteer in child care? ☐Y ☐N ☐U

Patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U

Is patient a student? ☐Y ☐N ☐U

Type of school:

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U

Give details:

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

BEHAVIORAL RISK & CONGREGATE LIVING

During the one month prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐Y ☐N ☐U

Name of facility:_____

Dates of contact: _____

During the one month prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐Y ☐N ☐U

If yes, specify:_____

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) _____
- ☐ Unknown

HEALTH CARE AND BLOOD & BODY FLUID EXPOSURE RISKS

During the one month prior to onset of symptoms, was the patient employed as a laboratory worker? ☐Y ☐N ☐U

Notes:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U

If yes, specify:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐Y ☐N ☐U

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

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

Who was interviewed?

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

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ☐Y ☐N ☐U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County_____

☐ Outside NC, but within US

City _____

State _____

County_____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐Y ☐N

Notes:

VACCINE

Has patient/contact ever received vaccine related to this disease? ☐Y ☐N ☐U

Vaccine type:_____

☐ Unknown vaccine or immune globulin

Year of last dose received: _____

Age when last dose received: _____

Number of doses received: _____

How many days prior to illness onset was vaccine received?

☐ Fewer than 14 days ☐ 14 days or more

Was vaccination pre-exposure or post-exposure?

☐ Pre-exposure

☐ Post-exposure

Vaccine "take" recorded at 7 days?... ☐Y ☐N ☐U

Result:

☐ Major ☐ None

☐ Equivocal ☐ Unknown

Was vaccination during this outbreak?... ☐Y ☐N ☐U

Source of vaccine information:

- ☐ Patient's or Parent's verbal report
- ☐ Physician
- ☐ Medical record *(Note: Any vaccine on a medical record should be recorded in the NCIR)*
- ☐ Certificate of immunization record *(Note: Any vaccine on a certificate of immunization should be recorded in the NCIR)*
- ☐ Patient vaccine record
- ☐ School record
- ☐ Other, specify:_____
- ☐ Unknown

Vaccinia

2007 Case Definition (North Carolina)*

Clinical description

Rash (macular, papular, vesicular, or pustular, generalized or localized, discrete or confluent).

and one or more of the following symptoms/signs:

Fever, chills, sweats, headache, backache, lymphadenopathy, sore throat, cough, shortness of breath.

Epidemiologic criteria

Exposure to a suspect, probable or confirmed human case of vaccinia or a person who has been vaccinated against smallpox with vaccinia virus.

Laboratory criteria for diagnosis

Confirmed:

- Isolation of vaccinia virus in culture.

  or
- Demonstration of vaccinia virus DNA by PCR testing of a clinical specimen.

Probable:

- Demonstration of virus morphologically consistent with an orthopoxvirus by Electron Microscopy (EM) in the absence of exposure to another orthopoxvirus.
- Demonstration of the presence of orthopoxvirus in tissue using immunohistochemical (IHC) testing methods in the absence of exposure to another orthopoxvirus.

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed for Vaccinia

Probable: a clinically compatible case that meets epidemiologic criteria and probable laboratory criteria for Vaccinia

Suspect: a clinically compatible case that meets epidemiologic criteria for Vaccinia that is awaiting results of laboratory testing

Comment:

*The Centers for Disease Control do not have a CSTE approved case definition for Vaccinia.