

**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.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**MONKEYPOX
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 72**

**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



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): / /

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
 Generalized Bilateral
 Regional Unknown
 Unilateral

Location
 Preauricular Inguinal Axillary
 Cervical Femoral Other

Tenderness
 Tender Non-tender

Headache Y N U

Encephalopathy Y N U

Backache/back pain 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

Location:
 All over the body (generalized)
 Generalized, predominately central/torso/back (centripetal)
 Generalized, predominately face/hands/feet (centrifugal)
 Localized/Focal
 Palms and soles
 Unknown

Appearance of rash (choose all that apply):
 Macular Papular Pustular Unknown
 Petechial Bullous Vesicular

Further appearance of rash
 Discrete Confluent Unknown

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

Conjunctivitis Y N U

Corneal ulcer(s) or keratitis 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

Did the patient have a chest x-ray? Y N U

If yes, describe (check all that apply):
 Normal
 Infiltrate
 Diffuse infiltrates / findings suggestive of ARDS
 Mediastinal widening
 Pleural effusion
 Hilar adenopathy
 Other _____

Chest CT scan performed Y N U

Date performed (mm/dd/yyyy): _____

Describe (check all that apply)
 Normal
 Infiltrate
 Pleural effusion
 Hilar adenopathy
 Mediastinal adenopathy
 Other _____

INFANT BIRTH DETAILS

If patient was pregnant during the 19 days prior to onset of symptoms, give infant birth details:
Where was the child born?
 Hospital
 Home
 Other
 Unknown

Hospital or facility where infant was born: _____

Infant gestational age at birth:
 Full term
 Premature
 Unknown

Number of weeks gestation _____

Vital status:
 Born alive and still alive
 Born alive and then died
 Stillborn
 Unknown

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

Give cause of death from death certificate: _____

Was an autopsy performed? Y N U
If yes, give final pathological diagnosis: _____

Did patient experience onset of symptoms within 6 weeks of delivery? Y N U

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PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U
Specify _____

Injury/Wound/Break in skin Y N U
Anatomic site _____
Circumstances _____
Principal wound type
 Animal bite
 Other (e.g. with cancer)
 Unknown

TREATMENT

Did the patient receive an antiviral for this illness? Y N U
Specify antiviral name: _____
Notes: _____

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): ____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N
Date control measures issued: ____/____/____
Date control measures ended: ____/____/____
Was patient compliant with control measures? Y N
Did 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

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): ____/____/____
Autopsy performed? Y N U
Patient autopsied in NC? Y N U
County of autopsy: _____
Autopsied outside NC, specify where: _____
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
 Refugee
 Recent Immigrant
 Foreign Adoptee
 None of the above

Did patient travel during the 19 days 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:

Additional travel/residency 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: _____

BEHAVIORAL RISK & CONGREGATE LIVING

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 FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 19 days prior to onset of symptoms, did the patient work in a laboratory? Y N U
If yes, specify and give details: _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
If yes, specify: _____

OUTDOOR EXPOSURE

During the 19 days prior to onset of symptoms, did the patient participate in any outdoor activities? Y N U
Specify outdoor activities (check all that apply):
 Hunting, trapping
 Skin/eviscerate (gut) wild animal
 Contact with wild animal carcass
Was patient exposed to wild animals? Y N U
Select animal exposure(s)
 Ground squirrel(s)
 Mice
 Rabbit(s) (hares) or rabbit tissue
 Squirrel(s)
 Other _____
 Unknown animal species
Did patient handle the animal? Y N U
Animal was:
 Alive Dead Unknown
Was animal sick? Y N U
Exposed on (date) (mm/dd/yyyy): ____/____/____
Until (date) (mm/dd/yyyy): ____/____/____

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ANIMAL EXPOSURE

During the 19 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)? Y N U
If yes, specify and give details:

Household pets? Y N U
If yes, specify and give details:

Was pet sick? Y N U

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor? Y N U
If yes, specify and give details:

Did patient handle any animals? Y N U
Species:

Did it/they appear sick? Y N U

Did patient work with smallpox vaccine or other orthopox vaccines? Y N U
If yes, specify and give details:

Did patient necropsy animals? Y N U
If yes, specify and give details:

Did patient work with moneypox virus or other orthopox virus? Y N U
If yes, specify and give details:

Did patient work with animal importation? Y N U
If yes, specify and give details:

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

Did the patient work at or visit a fair with livestock or a petting zoo? Y N U
If yes, specify and give details:

Did the patient work at or visit a zoo, zoological park, or aquarium? Y N U
If yes, specify and give details:

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U
If yes, specify and give details:

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:

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:

VACCINE

Has patient/contact ever received vaccine for this disease? Y N U
If yes, provide the vaccine name, source of vaccine, date of vaccination, and source of vaccine information:

Monkeypox

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 MPX, or
- Exposure to a wild, captive, or pet mammal with, or without, one or more of the following clinical signs/symptoms: conjunctivitis, respiratory symptoms, lymphadenopathy and/or rash, and
 - linked to a MPX-endemic area of Africa, or
 - linked to a confirmed zoonotic outbreak of MPX in another area of the world, or
 - linked to contact with a mammalian or human case of MPX

Laboratory criteria for diagnosis

Confirmed:

- Isolation of MPX virus in culture. or
- Demonstration of MPX 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 MPX

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

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