

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

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.

Table with patient information: 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.

Table for lab results with columns: Specimen Date, Specimen #, Specimen Source, Type of Test, Test Result(s), Description (comments), Result Date, Lab Name—City/State

CLINICAL FINDINGS section containing various medical questions and checkboxes such as 'Is/was patient symptomatic for this disease?', 'Elevated CSF protein', 'Skin lesions', 'Respiratory paralysis', etc.

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? _____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N
Check all that apply:
 Work Sexual behavior
 Child care Blood and body fluid
 School 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

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC Refugee
 Resident of another state or US territory Recent Immigrant
 Foreign Visitor 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: _____

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

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): ____/____/____

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? ____/____/____

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): ____/____/____

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?

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

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.