North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

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

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

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):____/____/____

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, predomiately 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

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

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):____/____/____

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

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 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:

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:

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 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