**TDH Mpox (Monkeypox) Case Report Form**

Adapted from CDC’s Short CRF [OMB No. 0920-1011Exp. Date 01/31/2023]. *Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011*

**NOTE FOR DISEASE INTERVENTION SPECIALISTS/ CASE INVESTIGATORS:** This form was developed to collect objective data around mpox cases. These interviews should be conducted by those skilled at quickly developing rapport with individuals and soliciting sensitive information, especially around sexual behaviors. Please use best practices and skills learned from past experience/training to collect this information. **It is acceptable and expected that you may need to ask a question in a more open-ended way than the data collection form indicates in order to complete a successful interview.** For example, it is likely more effective to say “When was the last time you had sex or close intimate contact?” rather than “Did you engage in sex and/or close intimate contact?”. Please ensure that, no matter how the question is phrased to the case, you can accurately answer the question as it is written on the form.

If the individual is unwilling to provide sufficient time to answer all questions in the case report form, please prioritize asking those that are denoted by an asterisk (\*). If the individual is willing to receive a call-back, consider asking the remaining questions later.

Questions in BLUE are not part of CDC’s Case Report Form, but are required for TDH data collection purposes.

Questions in GRAY are part of CDC’s Case Report Form and are included here for continuity…. But do not need to be completed at the time of the case interview.

**Interview Information**

1. Interviewer Name:
2. TN Public Health Jurisdiction:
3. Date of interview:
4. Indicate who will be interviewed/how information will be gathered (select all that apply)

Patient

Proxy

Provider

Other;

Specify:

1. \*Is the patient deceased?  Yes  No  Unknown
2. If deceased, did they die from this illness?  Yes  No  Unknown
3. If deceased, date of death:
4. (FOR INTERVIEWER) Reporting State/Territory
5. (FOR INTERVIEWER) If a Tribal Area, specify
6. (FOR INTERVIEWER) Interviewer agency
7. (FOR INTERVIEWER) Are you reporting a confirmed case of orthopoxvirus infection or mpox?  Yes  No

**Patient’s Public Health Identifiers**

1. Patient ID (person-level identifier; if available, NBS ID)

**Patient Demographics**

1. Case Name:
2. Case Phone number:
3. Date of birth:
4. \* [If DOB unavailable] What is your age, in years?
5. What is your weight, in pounds? (NOTE to interviewer: This info is needed in order to determine treatment dosage, if needed)
6. \* Do you currently describe yourself as male, female, or transgender (select all that apply)

Male

Female

Transgender male

Transgender female

Another gender identity; Specify

Refused

1. \* What sex were you assigned at birth?

Male

Female

Refused

1. \* Which of the following best represents how you think of yourself?

Gay or lesbian

Straight (not gay or lesbian)

Bisexual

A different term; Specify

Prefer not to answer

1. \* What is your race (select all that apply)?

American Indian or Alaska Native; Specify tribal affiliation

Asian

Black or African American

Native Hawaiian or Other Pacific Islander

White

1. \* What is your ethnicity?

Hispanic or Latino

Non-Hispanic or Latino

1. Describe your employment position/role:

Are you a healthcare worker?  Yes  No

Healthcare facility name:

1. \* [If female sex at birth] Are you currently pregnant?  Yes  No  Unknown
2. Are you currently breastfeeding?  Yes  No

**Household demographics**

1. Do you reside in the U.S.?  Yes  No
2. What state/territory do you reside in?
3. You mentioned you reside in a Tribal Area, please specify.
4. \* [If address unavailable] What county do you reside in? (in other words, the county used in your address)
5. You mentioned that you don't live in the US, so what city do you reside in?
6. You mentioned that you don’t live in the U.S., so what country do you reside in?

**Patient illness characteristics**

1. \* What symptoms did you experience during the course of your illness? (FOR INTERVIEWER: probe for each listed symptom) (select all that apply)

Fever (temperature greater than 100.4)

Rash (includes any lesions)

Abdominal pain

Chills

Conjunctivitis

Enlarged lymph nodes

Eye lesions

Headache

Malaise (general feeling of illness/weakness)

Myalgia (muscle aches)

Proctitis

Pruritis (itching)

Pus or blood on stools

Rectal bleeding

Rectal pain

Tenesmus/urgency to defecate

Vomiting or nausea

Specify:

Other;

1. (FOR INTERVIEWER) Any evidence of ocular involvement (ocular lesions, keratitis, conjunctivitis, eyelid lesions)?

Yes  No  Unknown

1. \* What was the date of your illness onset (in other words, the date when any of the symptoms you mentioned first appeared)?
2. You mentioned you had a rash, what was the date of the rash onset?
3. Where on your body did the rash spread during the course of your illness? (select all that apply)

Eyes  Arms

Face

Head

Neck

Mouth,

Lips, or oral mucosa

Trunk

Legs

Palms of hands

Soles of feet

Genitals

Perianal (Anus or Anal region)

Other location; Specify

1. (FOR INTERVIEWER) Has this individual been diagnosed with any acute infections other than mpox during this current illness/or within the last three weeks (e.g., gonorrhea, chlamydia, syphilis, HSV, other STI, varicella)?  Yes  No  Unknown

If yes, please specify infections

1. \* Have you ever been hospitalized for this illness?  Yes  No
2. If yes, what was the reason for the hospitalization? (choose all that apply)

Breathing problems requiring mechanical ventilation

Breathing problems not requiring mechanical ventilation

Treatment for secondary infection

Pain control

Disseminated disease

Exacerbation of underlying condition (e.g. autoimmune or skin condition)

Other; Specify:

1. You mentioned you were hospitalized for this illness, approximately how long, in days, were you hospitalized?

\*Healthcare Facility Name

Date of admission

Date of discharge

1. (FOR INTERVIEWER) If known, start date of patient isolation
2. (FOR INTERVIEWER) If known, end date of patient isolation (all lesions have resolved, the scabs have fallen off, and a fresh layer of intact skin has formed)
3. (FOR INTERVIEWER, may need to request medical records for this information) Did this patient receive anti-orthopoxviral treatment (such as tecovirimat or TPOXX, an oral or intravenous medication to treat MPX)?
4. (FOR INTERVIEWER, may need to request medical records for this information) Did the patient receive post-exposure prophylaxis?

Yes, ACAM2000

Yes, JYNNEOS

No

Unknown

1. (FOR INTERVIEWER, may need to request medical records for this information) Did the patient receive pre-exposure prophylaxis?

Yes, ACAM2000

Yes, JYNNEOS

No

Unknown

1. If yes, approximately how many days after initial exposure did the patient receive post-exposure prophylaxis?

**Patient Medical History**

1. \* (FOR INTERVIEWER, if unknown in NBS) What is the individual’s HIV status?  HIV positive  HIV negative  Unknown
2. If HIV positive, was the individual’s viral load undetectable when it was last checked?  Yes  No  Unknown
3. If HIV positive, is the patient currently taking medication for treatment?  Yes  No  Unknown

Please list medication(s):

1. Do you have any known immunocompromising conditions (excluding HIV) or take immunosuppressive medications? Immunocompromising conditions can include diseases like diabetes, lupus, organ transplants, stem cell transplants, and cancer. Certain medicines like chemotherapy, biologic therapies, and steroids can also weaken the immune system.  Yes  No  Unknown

If yes, please specify:

**Smallpox Vaccine History**

1. (FOR INTERVIEWER) Is there documented administration of smallpox vaccine prior to May 1st, 2022?  Yes  No  Unknown
2. If yes, when was the patient vaccinated (Indicate all dates)
3. If yes, what year(s) were you vaccinated?

**Understanding Exposure:**.

1. (FOR INTERVIEWER) Is this case epi-linked to another confirmed/probable case?  Yes  No  Unknown
2. If yes, provide source case’s Name, DOB, NBS ID (if available):
3. If yes, was the patient identified through contact tracing?  Yes  No  Unknown

Then, SKIP AHEAD TO “**ELICITING CONTACTS**” Section. If NOT linked to another case (route of transmission is unknown), continue with additional questions in **UNDERSTANDING EXPOSURE** section

1. \* In the 3 weeks before your first symptom appeared (also called symptom onset), did you have any interaction with anyone who had symptoms of mpox or mpox-related illness when you interacted with them?  Yes  No  Unknown

If yes, describe:

1. \* In the 3 weeks before your first symptom appeared (also called symptom onset), have you attended any large public or private events? For example, like concerts, weddings, festivals, or parades?  Yes  No  Unknown

If yes, describe:

1. \* In the 3 weeks before your first symptom appeared (also called symptom onset), did you engage in any sex (vaginal, oral, or anal) and/or close intimate contact (cuddling, kissing, touching partner’s genitals or anus, or sharing sex toys)?  Yes  No  Unknown

If yes, can you describe who you interacted with and the approximate number of partners for each?

Women; Number

Men; Number

Other gender identity; Number

Unknown

**Eliciting Contacts.** Now we’re going to focus on anyone you may have been in close contact with since your symptoms began. It’s important to identify these people so we can let them know that they’ve been exposed and should seek testing if they start to develop symptoms. It may also be possible for them to be vaccinated now (even after you’ve been in touch with them) so they don’t get sick.

1. First, let’s start with where you’ve been living since your illness onset?

Single family dwelling

Multi-family dwelling

Hotel

Congregate housing (hostel, shelter, university/dormitory, prison/jail); Specify:

Unsheltered (no dwelling)

Other; Specify:

**COLLECT THE FOLLOWING INFORMATION FOR EVERY CLOSE CONTACT** identified from symptom onset through symptom resolution (or date of interview if symptoms are not resolved). “Close contact” includes those who were within 6 feet of you for 15 minutes or more.

* Highest Priority: Sexual/Intimate Contact Partners; Household members, Healthcare workers who treated case without PPE
* Lower Priority: Coworkers, Friends, Healthcare workers who treated case with PPE
* Non-Priority (do not need to collect information on these individuals): Individuals the case may have had brief, non-close contact with (no sexual/intimate contact, and or not within 6 feet for at least 15 minutes)

1. Name
2. What is the current gender of this person?

Male

Female

Transgender male

Transgender female

Another gender identity

Refused

1. How old is this person in years?
2. **What type of interaction did you have with them? (Select all that apply**)

Caregiving

Household contact

Healthcare contact

Sexual and/or close intimate contact

Shared food, utensils, or dishes

Shared clothing

Shared towels or bedding either at home or at another location

Shared transportation (carpooling, riding a bus, riding a motorcycle, using a tax, using rideshare);

specify type(s)

Share bathrooms (toilets, sinks, showers) either at home or at another location

Face-to-face contact, not including sexual/intimate contact (being within 6 feet for more than 3 hours of an unmasked case patient without wearing, at a minimum, a surgical mask)

Other;

Specify:

1. Date(s) of your interactions with them

Dates include exposure period (3weeks before symptoms began)

Dates include infectious period (symptom onset – symptom resolution (or present date if symptoms ongoing))

1. Has that person experienced any symptoms of mpox?  Yes  No  Unknown

If yes, please describe:

If yes, when did their symptoms begin? (mm/dd/yyyy)

1. Have they received a positive lab test for mpox?  Yes  No  Unknown
2. Has a healthcare provider diagnosed them with mpox?  Yes  No  Unknown
3. Which city and state (or country if out of the U.S.) did you interact with them?

IF CONTACT WAS EXPOSED DURING THE CASE’S INFECTIOUS PERIOD:

Because you had close contact with this person while you were infectious with mpox, there is the potential that they might also develop mpox. It’s very important that we notify them that they may have been exposed, so they can be on the lookout for symptoms and seek healthcare if they become ill. Do you have any contact information for them? Your identity will be kept confidential when we reach out to them.

1. Contact’s phone number:
2. Contact’s email address:
3. Contact’s preferred method of contact for public health monitoring (complete after contact has been notified)

Text message

Email

If case cannot/will not provide contact information, urge the importance of sharing this information with them: [TDH Mpox Guidance for Contacts](https://www.tn.gov/content/dam/tn/health/documents/reportable-diseases/Monkeypox-Contact-Guidance.pdf)

**Travel History**.

1. \* Did you travel during the 3 weeks before your first symptom appeared?  Yes  No  Unknown
2. Have you traveled since your first symptom appeared?  Yes  No  Unknown

FOR INTERVIEWER: IF YES TO EITHER OF THE ABOVE, CONTINUE TO THE FOLLOWING QUESTIONS CONCERNING THESE TRIPS.

1. Was your travel domestic or international?  Domestic  International
2. Where and how did you depart for your travel (mode of transportation, depart/arrival city, departure date)?
3. Where and how did you return from your travel (mode of transportation, depart/arrival city, return date)?

**Household Pets**

1. Do any pets live in your household?  Yes  No  Unknown
2. You mentioned that pets live in your household, which type of animal(s) are they? (select all that apply)

Specify:

Dog  
 Cat  
 Small rodent (rat, mouse, guinea pig, sugar glider, hamster, gerbil, etc.)  
 Rabbit  
 Livestock (cow, horse, goat, sheep, pig, etc.)  
 Other, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you very much for your time and thoroughness. We’d like to continue to check in with you over the course of your illness. We can conduct these check-ins by text or email, and it will consist of a short (1 minute) survey where you can let us know how you’re doing and if you need assistance seeking medical care. Would you prefer we contact you by text or email?

Text; phone number:

Email; email address:

Case declined ongoing monitoring by public health

**Post-Interview**

1. What was the date of likely exposure?
2. What was the likely source of exposure?
3. Please add any additional notes: