	Mpox Contact Management Form V2.6 – 24/07/23[1]	

1. Summary Contact Details

CONTACT NAME: ____ **DoB:** ____________

CONTACT ID: [ ] **HSE-Area**: [ ] **County**: [ ]

RHA: [ ] **CHO:** [ ]

Healthcare Worker: Y ☐ N ☐ **Contact Phone**: [ ]

Date case identified: ____/____/______

Type of Surveillance:		**Risk Categorisation:**	
Passive (Cat 3):	☐	Low Risk:	☐
Active (Cat 2):	☐	High Risk:	☐

Date/Time Surveillance began: ____/____/______ ____:____

Vaccinated: Y ☐ N ☐ Vaccine Brand: _____________

Route: subcutaneous ☐ intradermal ☐

Date vaccinated: Dose 1 __/__/__ Dose 2: __/__/_

[1] To be completed in conjunction with Checklist for Public Health on management of mpox cases and their contacts document and Community Contact Tracing Matrix and/or HCW matrix.

2. Summary Case Details

Name: ____

CASE CIDR ID: [ ]

Dob: ____________

Nationality: ____________________ **Country of Exposure**: ____________________________

Current location: ____

3. Full Contact Details

Name: ____

Address: ____

____

County: ____________________ **CHO:** ________________ **Eircode:** ______________

Phone: ______________________________ **DoB:** ____/____/_____

Nationality: __________________ **Country of birth:** __________________________

Sex: Male ☐ Female ☐ Trans male ☐ Trans female ☐ Non-binary ☐ Unk ☐

HCW: Y ☐ N ☐ **DOB:** ___/___/______ **Age:** ____________________

Occupation: __________________________

GP Name: ___________________________________ **GP Phone**: __________________

Seen by GP? Y ☐ N ☐ Unk ☐ **Date/Time:** ____/____/______ _____:____

Significant past medical history: ____

____

Pregnant: Y ☐ N ☐ Unk ☐ **Immunocompromised**: Y ☐ N ☐

Did they previously receive the smallpox vaccine? Y ☐ N ☐

If yes, year of vaccination: __________________

Smallpox vaccination (scar): Y ☐ N ☐ Unk ☐

Has the contact been referred for vaccination?

Referred for vaccination ☐ Declined ☐ Already vaccinate ☐ Not offered – outside 14-day window ☐ Not offered as per risk matrix ☐ Not offered – other☐

If not, why?____

Vaccinated with Imvanex? Y ☐ N ☐ Date: ____/____/___ Batch No: _____________

(If no, give reason____)

Info for Vaccine Referral Form

PPSN: __________________________________

Next of kin name: __________________________________

Next of kin contact number (mobile): __________________________________

Please indicate if referral is recommending a 2nd dose: Y ☐ N ☐ Unk ☐

Referrer name: ____________________________________

Referrer contact number: ____________________________________

GP Practice Name: ____________________________________

Nature of Contact:	**Type of Contact:**
• Household: Y ☐ N ☐ • Sexual: Y ☐ N ☐ • Healthcare: Y ☐ N ☐ • Workplace (non-HC) : Y ☐ N ☐ • Community: Y ☐ N ☐ • Other: Y ☐ N ☐ (*If Other, please specify*	• Indirect: ☐ • Direct: ☐ For episodes of Direct Contact, specify extent/nature of contact/sexual/PPE breach: ________________________________ ________________________________ ________________________________ ________________________________ ________________________________
________________________________)	
Date of last Contact: __/____/_____	**Ongoing exposure:** Y ☐ N ☐
Risk Categorisation: Category 2: ☐ Category 3: ☐	

5. Daily Symptom Check[2]

Is the case currently symptomatic: Y ☐ N ☐ **Onset**

Symptom	Y/N	Onset
Fever	Y ☐ N ☐	_____/____/_____ _____:____
Chills	Y ☐ N ☐	_____/____/_____ _____:____
Headache	Y ☐ N ☐	_____/____/_____ _____:____
Exhaustion	Y ☐ N ☐	_____/____/_____ _____:____
Swollen glands	Y ☐ N ☐	_____/____/_____ _____:____
Cough/sore throat	Y ☐ N ☐	_____/____/_____ _____:____
Backache	Y ☐ N ☐	_____/____/_____ _____:____
Muscle ache	Y ☐ N ☐	_____/____/_____ _____:____
Rash	Y ☐ N ☐	_____/____/_____ _____:____
Macules	Y ☐ N ☐	_____/____/_____ _____:____
Papules	Y ☐ N ☐	_____/____/_____ _____:____

[2] These are for use if the contact develops symptoms and is for assessment as a probable case – complete only if symptoms develop. Check any symptoms against the HMI Case Definition in Appendix 1 (below).

Vesicles	Y ☐ N ☐	_____/____/_____	____:____
Pustules	Y ☐ N ☐	_____/____/_____	____:____
Umbilicated	Y ☐ N ☐	_____/____/_____	____:____
Scabs	Y ☐ N ☐	_____/____/_____	____:____
Anogenital/orolabial	Y ☐ N ☐	____________________	
Describe Anogenital/oro labial rash:	____________________		

6. Escalation

Date/Time Escalation: ____/____/______ ____:____

Basis for escalation: ____

Referred to: ____

Action Taken: ____

Admitted: Y ☐ N ☐ **Date/Time**: ____/____/______ ____:____

7. Exit from Surveillance

Date/Time: ____/____/______ ____:____

Appendix 1: Mpox Case Definition

See the Interim mpox case definition.

Appendix 2: Daily Active Surveillance/Quarantine Log[3]

Surveillance Day	Day/Date	Phoned Y/N	Time of Call	Fever[4] Y/N	Other Symptoms Y/N	Comments/Actions
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

[3] Can be used for Passive/Active Surveillance and Active Surveillance + Quarantine

[4] If fever or other symptoms develop, complete Section 5 - Daily Symptom Check

Surveillance Day	Day/Date	Phoned in Y/N	Time of Call	Fever[5] Y/N	Other Symptoms Y/N	Comments/Actions
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						

[5] If fever or other symptoms develop, complete Section 5 - Daily Symptom Check