

Mpox

CASE INVESTIGATION FORM (CIF) V2.0

**MPXV Clade I**

**CASE INVESTIGATION FORM (CIF) MPXV Clade I**

This case investigation form (CIF) is designed by WHO to collect data obtained from persons with suspected, probable, or confirmed mpox infection. It has been agreed by the National Incident Management Team 27th August 2024 to use this form to collect data on cases of mpox due to MPXV Clade I, for initial cases.

**The CIF MPXV Clade I is available for use from 12th September 2024 until further notice**.

If the case is a probable, or confirmed mpox MPXV Clade II case please continue to use Mpox case investigation and Enhanced Surveillance Form which is available on the HPSC website; Information for health & care workers[- forms section](https://www.hpsc.ie/a-z/zoonotic/monkeypox/guidance).

**Case investigation form (CIF) – for suspected, probable or confirmed mpox cases due to MPXV Clade I**

**Module 1: Case identification**

**Module 2: Epidemiological investigation**

**Module 3: Disease Severity, Case Outcome and Laboratory Information**

**Module 4: Forward Contact Tracing and Contact follow-up**

This form is intended to collect data to allow the in- depth investigation and follow-up of mpox cases to better characterize key epidemiological and clinical features of infection, and understand spread, severity, and spectrum of disease. The content of the form is based on previously acquired knowledge on mpox and insights coming from the current outbreak

**Form A1: Case investigation form (CIF) – for suspected, probable or confirmed mpox cases**

MODULE 1. CASE INFORMATION

**CIDR Event ID:**

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| --- |
| **DATA COLLECTOR INFORMATION** |
| **Name of data collector** |  |
| **Data collector role** |  |
| **Data collector institution** |  |
| **Data collector telephone number** |  |
| **Data collector email** |  |
| **Form completion date** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| **Date of notification** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |

**1a. CASE CLASSIFICATION**

☐ Suspected ☐ Confirmed ☐ Probable ☐ Unknown

**1b. CURRENT STATUS**

☐ Alive ☐ Dead ☐ Unknown/lost to follow up

|  |
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| **1c. CASE IDENTIFIER INFORMATION** (Unk = Unknown) |
| **First name** |  [For local use only – Do Not send to HPSC] |
| **Family name** |  [For local use only – Do Not send to HPSC] |
| **Date of Birth** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| **If date of birth is unknown, record** | Age [\_ \_][\_ \_]yearsOR if less than 2 years[\_ \_][\_ \_] months OR [\_ \_][\_ \_] days |
|
| **For children <5 years old** | Weight \_ \_ gramsHeight cmMid-upper arm circumference (MUAC) cm |
| **Is the child <5 years malnourished?** | ☐Yes ☐No ☐Unk |
| **Sex at birth** | ☐Male ☐Female ☐Unk ☐ Other(specify)  |
| **Gender** | ☐ Male ☐Female ☐Transmale ☐Transfemale ☐Non-binary ☐Unk ☐Other(specify)  |
| **Sexual behavior** | ☐ MSM ☐ Lesbian ☐ Heterosexual ☐ Bisexual ☐ Other ☐ UnkIf other, specify:  |
| **Individual’s national identification** |  |
| **number (if applicable):** |  |
| **Country of residence** |  [For local use only – Do Not send to HPSC] |
| **Telephone number** |  [For local use only – Do Not send to HPSC] |

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|  |  |
| --- | --- |
| **Email** |  [For local use only – Do Not send to HPSC] |
| **Address** |  |
| **Occupation of the case** |  |
| **Health worker?** | ☐Yes ☐No ☐Unk*If Health worker Yes, please complete the specific Section 2d.* |
|
| **Sex worker?** | ☐Yes ☐No ☐Unk |
| **Is the case an internally displaced** | ☐Yes ☐No ☐Unk |
| **person or a refugee** |  |
| **Does the case live in an Internally****Displaced People’s (IDP) or refugee****camp?** | ☐Yes ☐No ☐UnkIf Yes, name of the Camp:  |
|

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| **1d. HEALTH-CARE CENTRE/TREATING PHYSICIAN’S DETAILS** |
| **Name of health-care centre** |  |
| **Type of healthcare centre (e.g Sexual health clinic, General****Practitioner, hospital emergency room)** |  |
| **Name of treating physician** |  |
| **Telephone** |  |
| **Address** |  |

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| **1e. CURRENT MEDICAL HISTORY** (Unk = Unknown) |
| **Sexually Transmitted Infections (STI) in the last year** | ☐Yes ☐No ☐Unk | **Pregnancy** | ☐ Yes, Pregnancy, trimester unknown☐ Yes, Pregnancy, 1st trimester*(1st trimester is from week 1 to the end of week 12)*☐ Yes, Pregnancy, 2nd trimester(*2nd trimester is from week 13 to the end of week 26)*☐ Yes, Pregnancy, 3rd trimester,(*3rd trimester is from week 27 to the end of the pregnancy)*☐ Post-partum (<6 weeks)☐ No☐ Unk |
| **Chlamydia** | ☐Yes ☐No ☐Unk |
| **Gonorrhea** | ☐Yes ☐No ☐Unk |
| **Genital herpes** | ☐Yes ☐No ☐Unk |
| **Lymphogranuloma venereum (LGV)** | ☐Yes ☐No ☐Unk |
| **Mycoplasma genitalium** | ☐Yes ☐No ☐Unk |
| **Syphilis** | ☐Yes ☐No ☐Unk |
| **Trichomonas vaginalis** | ☐Yes ☐No ☐Unk |
| **Genital warts** | ☐Yes ☐No ☐Unk | **Immuno- suppressed** | ☐Yes, due to disease☐Yes, due to medication☐Yes, reason unknown☐No ☐Unk |
| **Other STIs** | ☐Yes ☐No ☐Unk |
| **If Other STI Yes, specify:** |
| **If Immunosuppressed, specify the cause of the immunosuppressed status:**  |
| **Is the case taking HIV pre-exposure prophylaxis (PrEP)?** | ☐Yes ☐No ☐Unk |

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| **HIV status** | ☐Positive |  | ☐Self-reported☐Laboratory-confirmed☐Medical record☐Unk |
| ☐Negative | **HIV status** |
| ☐Unk | **assessment** |
|  |  |
| **If HIV positive** | **Viral load:** ☐Undetectable | ☐Detectable | ☐Unk |
| **Most rec** | **ent CD4 counts**  |  |  | ☐Unk |
| **HIV treatment:** | ☐Yes |  | ☐No | ☐Unk |  |
| **Was the case ever diagnosed with****mpox previously?** | ☐Yes | ☐No |  |  | ☐Unk |  |  |  |

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| **1f. PRE- OR POST-EXPOSURE VACCINATION** (Unk = Unknown) |
| **What antiviral treatment is the case receiving for mpox?** (Select all that apply) | ☐Tecovirimat☐Brincidofovir☐Cidofovir☐Other (specify)☐On treatment, but name of antiviral treatment not known☐No antiviral treatment☐Unk |
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|
| **Has the case received smallpox vaccine?** | **Date when the case received the latest dose of smallpox vaccine?**[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_](If the case does not recall the exact date of vaccination, please report only the year or an approximate date)[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| ☐Yes ☐No ☐Unk |
| **Did the case receive mpox vaccination****and how many doses of vaccine received?** | ☐ 0 dose unvaccinated☐ 1 dose☐ 2 doses☐ Vaccinated with unknown number of doses☐ Unknown vaccination status |
| **Did the case receive a first dose of mpox vaccine?**☐ Yes – pre-exposure prophylaxis☐ Yes – Post-exposure prophylaxis☐ No☐ Unknown | **Date of first dose smallpox/mpox vaccination***(approximate months and year if exact date is not known)*[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_]**Vaccine brand first smallpox/mpox vaccine**☐ ACAM2000☐ MVA-BN☐ LC16m8☐ Other☐ Unknown |
|
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|
| **Did the case receive a second dose of mpox vaccine?**☐ Yes – pre-exposure prophylaxis☐ Yes – Post-exposure prophylaxis☐ No☐ Unknown | **Date of second dose smallpox/mpox vaccination***(approximate months and year if exact date is not known)*[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_]**Vaccine brand second smallpox/mpox vaccine**☐ ACAM2000☐ MVA-BN |
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☐ LC16m8

☐ Other

☐ Unknown

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| **1g. SIGNS AND SYMPTOMS IF CASE IS/HAS BEEN SYMPTOMATIC** (Unk = Unknown) |
| **Does the case present/has the case** | ☐Yes | ☐No | ☐Un | k |  |  |
| **presented with any symptoms related** |  |  |  |  |  |  |
| **to mpox?** |  |  |  |  |  |  |
| **Date of first clinical diagnosis** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | ☐Unk |
| **Date symptoms onset (date of** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| **first/earliest symptom)** |
| **Date onset of rash** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |  | ☐Not applicable |
| **Skin/mucosal lesions (excluding oral or anogenital areas)** | ☐Yes ☐No ☐Unk | **Sore throat** | ☐Yes ☐No ☐Unk |
| **Skin/mucosal lesions where the** | ☐Yes ☐No ☐Unk | **Localized** | ☐Yes ☐No ☐Unk |
| **location is not known** | **lymphadenopathy** |
| **Anogenital skin/mucosal lesions** | ☐Yes ☐No ☐Unk | **Generalized** | ☐Yes ☐No ☐Unk |
| **lymphadenopathy** |
| **Oral skin/mucosal lesions** | ☐Yes ☐No ☐Unk | **Lymphadenopathy** | ☐Yes ☐No ☐Unk |
| **where the location is****not known** |
| **Fever >38.5C** | ☐Yes ☐No ☐Unk | **Chills or sweats** | ☐Yes ☐No ☐Unk |
| **Asthenia (profound weakness)** | ☐Yes ☐No ☐Unk | **Headache** | ☐Yes ☐No ☐Unk |
| **Muscle pain (myalgia)** | ☐Yes ☐No ☐Unk | **Vomiting/nausea** | ☐Yes ☐No ☐Unk |
| **Genital soft-tissue oedema/swelling** | ☐Yes ☐No ☐Unk | **Cough/respiratory** | ☐Yes ☐No ☐Unk |
| **symptoms** |
| **Back pain** | ☐Yes ☐No ☐Unk | **Conjunctivitis** | ☐Yes ☐No ☐Unk |
| **Fatigue** | ☐Yes ☐No ☐Unk | **Diarrhea** | ☐Yes ☐No ☐Unk |
| **Anogenital pain and/or bleeding** | ☐Yes ☐No ☐Unk | **Other symptoms** | ☐Yes ☐No ☐Unk |
| **If Other symptoms Yes, specify:** |

**1h. COMPLICATIONS (Unk = Unknown)**

**Did the case develop complications? (Select all that apply)**

☐ None

☐ Acute respiratory distress syndrome

☐ Lower respiratory tract infection (e.g. pneumonia)

☐ Meningoencephalitis

☐ Myocarditis

☐ Corneal infection

☐ Retropharyngeal abscess

☐ Sepsis

☐ Severe Dehydration

☐ Still birth as pregnancy outcome in a case

☐ Skin and/or soft-tissue infection due to secondary bacterial infection

☐ Other secondary bacterial infection

☐ Other (please specify separately)

☐ Unknown

**If Complications is Other, please specify:**

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MODULE 2. EPIDEMIOLOGICAL INVESTIGATION

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| **2a. EXPOSURE TO ANOTHER PROBABLE OR CONFIRMED CASE (*up to 3 weeks prior to onset of symptoms or diagnosis*)** (Unk = Unknown) |
|
| ***Dates of 3 weeks:*** *from* [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] **to** [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| **Patient had contact with anyone presenting similar illness or symptoms; or with a known probable or confirmed case up to 3 weeks prior to symptom onset or diagnosis?** | ☐Yes☐No☐Unk | **How often did the contact occur?**☐Once☐Multiple times☐Unk | **For any of the encounters, what was the maximum duration (select only one)**☐<5 mins☐5<15 mins☐15 mins <1h☐1<4h☐ 4h+☐Unk |
| **Date of first contact** *(within the last three weeks)* | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |  |
| **Date of most recent contact***(within the last three weeks)* | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |  |
| *Please answer the following questions for each exposure event* |
| **Relationship to the case** | **Type of contact with the case** *(Select all that apply)*☐Prolonged face-to-face respiratory exposure in close proximity, but no physical contact☐ Direct skin to skin contact (such as touching, hugging), but no mucosal contact and no sexual intercourse☐Mouth to skin contact (kissing and oral sex)☐Sexual intercourse contact (Anal, and vaginal sex or touching of the genital or anal areas)☐Contact with contaminated material (such as clothing or bedding, including material dislodged from bedding or surfaces during handling of laundry or cleaning of contaminated rooms, sharing sex toys), but no direct contact with the case☐Health worker in contact with a case☐Unk☐Other, specify  |
| ☐ Spouse/partner |
| ☐ Household member |
| ☐ Non-household relative |
| ☐ Friend |
| ☐ Sexual partner |
| ☐ Colleague |
| ☐ Healthcare exposure |
| ☐ Other (specify) |
|  | ☐Household |  |  |
|  | ☐Workplace |  |  |
|  | ☐School/nursery |  |  |
| **Details of exposure:***(Select all that apply)* | ☐Healthcare setting (i☐Community☐Commercial sex ven☐Social event with sexual contact☐Unknown☐Other, specify: |  |

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|  |
| **Details of exposure setting****(Name and address; date):**[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| **Was the case symptomatic at****the time of contact?***Between date of onset to date* *the vesicle scab fell off*  | ☐Yes ☐No ☐Unk |

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| **2b. TRAVEL HISTORY (*up to 3 weeks prior to onset of symptoms or diagnosis*)** (Unk = Unknown)**Did the patient travel outside of or to other areas within the country in the past 21 days?** ☐Yes ☐No ☐Unk*The following questions should only be asked if patient reports “Yes”* |
|
| **Country****1.** | **Region** | **Date Entry**[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | **Date Departure**[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_ D\_][\_D\_] |
|
| **2.** |  |  |
| [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_ D\_][\_D\_] |
| **3.** |  |
| [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_ D\_][\_D\_] |
| **4.** |  |
| [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_ D\_][\_D\_] |
| **5.** |  |
| [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_ D\_][\_D\_] |
|  |  |

**Note for next two sections:**

• **Complete Section 2c** if exposure occurred in the household

• **Complete Section 2d** if the contact is a health worker (HW)

• **Skip to Section 2e** if none of the above is applicable

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| **2c. EXPOSURE IN HOUSEHOLD SETTING (*up to 3 weeks prior to onset of symptoms or diagnosis*)** (Unk = Unknown)*If exposure did not occur in the household, please skip to next Section* |
| **Location of household/Address of index case** |  |  |  |
| **Household size (number of people who lived in the** |  |  |  |
| **house in the last three months)** |  |  |  |
| **Age of each household member** | 1. | 4. |  |
|  |  |  |
| 2. 5. |  |
|  |  |  |
| 3. 6. |  |
| **Type of contact** | ☐ Kissing/hugging☐ Sharing a bathroom☐ Sharing a bed |
| *If more than 1 household contact being a probable or**confirmed case, then please provide information for* |
|

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*each* ☐ Direct physical contact

☐ Contact with contaminated items (linen, clothing, dishware / utensils etc...)

☐ Unk

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| **2d. OCCUPATIONAL EXPOSURE IN HEALTHCARE SETTING (*up to 3 weeks prior to onset of symptoms or diagnosis*)** (Unk = Unknown)*If the case is a Health worker who was exposed outside of work, please skip to next Section* |
| **Type of health worker:**(Role/Job title) | **Place of work:** |
| **Direct physical contact with the** ☐Yes**confirmed case** ☐No | **Indirect contact with a confirmed case** (e.g. ☐Yes being in the same room or having had contact ☐No |
| **(e.g. hands-skin physical contact)** ☐Unk | with contaminated surfaces or equipment) ☐Unk |
|  | ☐ Once |
| **How many times was the individual in contact with a** | ☐ Multiple times |
| **mpox case?** | ☐ NA |
| **Date(s) of contact with the case** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_][\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| *If contact multiple times, please fill in the following questions for each exposure* |
| **Description of the exposure** |  |
| **During the possible exposure was all appropriate personal protective equipment (PPE) used (gown, gloves, respirator, and eye protection)** | ☐Yes☐No☐ Some but not all PPE pieces☐Unk |
|
|
| **What PPE items were worn?** | ☐Gloves☐Gown☐Medical mask☐Respirator (e.g N95, FFP2, etc)☐Eye protection; Face shield or goggles |
|
|
|
| **Was there a breach of PPE whilst working or during removal of PPE?** | ☐Yes☐No☐Unk |
|
|
| **Did you perform hand hygiene before putting on PPE?** | ☐Yes☐No☐Do not recall |
|
|
| **Did you perform hand hygiene after removing PPE?** | ☐Yes☐No☐Do not recall |
|
|
| **Please provide more information on the exposure/s** |  |
| *(If necessary)* |  |

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| **2e. SEXUAL HISTORY** *(*Unk = Unknown) |
| **Number of sexual partners in the past 3 months****Number of sexual partners in the past 3 weeks****Sex of the sexual partners in the past 3 weeks** | ☐0 ☐1 ☐2-4 ☐4-9 ☐>10☐Unk☐0 ☐1 ☐2-4 ☐4-9 ☐>10☐Unk☐Only men ☐Only women ☐Bot☐Other ☐Unk | ☐Prefer not to say ☐NA☐Prefer not to say ☐NAh men and women |
| *The following questions should only be asked if the case reports one or more sexual partners in the last 3 weeks. Please answer the following for EACH contact* |
|
|  |  |  | ☐Yes, always |
| **Type of sex** | ☐Anal penetrative ☐Anal receptive |  | ☐Sometimes |
| **practiced** | ☐Oral ☐Vaginal | **Protected sex** | ☐No, never |
| *(Select all that apply)* | ☐Other (i.e sex toys, etc.) ☐Prefer not to say ☐NA | *(Using condom or**dental dam)* | ☐Prefer not to say☐Unk |

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| **2f. OTHER EXPOSURES (*up to 3 weeks prior to onset of symptoms or diagnosis*)** |
| **Direct or indirect contact with animals or their parts and products, other than commercially prepared meat products, in the three weeks prior to symptoms onset or diagnosis? Indirect contact includes contact with animal excreta, bedding, surfaces touched by the animal. etc** | ☐Yes ☐No ☐Unk |
| If YES, answer all below questionsIf NO, please skip to the next section |

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CIDR Event ID



|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of animal** | **Species, if****known, or any****other identifying characteristics** | **Frequency of****contact**a. Onceb. Multipletimes,*If yes, how many times (indicatively)*c. Unknown | **When did the****contact****occur?** [DD/MM/YYYY] or approximate time (e.g. a week before illness) (Repeat if there were multiple contacts) | **Where did the contact****occur?**a. Home b. Market c. Farmd. Workplace (e.g. veterinary clinic, zoo, etc)e. Outdoor, urban (e.g. parks, around homes)f. Outdoor, rural (e.g. forest)g. Other (specify) | **Exact location of****contact**(be as specific as possible – country, town/city) | **Type of contact with the animal**a. Huntingb. Slaughter and/or handling of raw meatc. Direct contact with live animal (e.g. petting,playing, licking, kissing, hand feeding)d. Bite/scratche. Consumption of raw/undercooked meat f. Indirect contact (e.g. animal excreta, bedding, surfaces touched by animal)g. Occupational contact (e.g. veterinary care)h. Other contact (specify)(Allow multiple options) | **At the time of contact,****the animal was:**a. Alive, with no apparent signs of diseaseb. Alive, with signs of disease (e.g. visible lesion, lethargy and/or lack of appetite)c. Killed/Deadd. Other (specify) |
| **Pets excluding rodents**(such as dogs, cats, birds, etc.) |  |  |  |  |  |  |  |
| **Rodent pets**(such as Guinea pigs, prairie dogs, gerbils, mice, rats, squirrels, etc.) |  |  |  |  |  |  |  |
| **Domestic animals**(cows, sheep, goats, etc.) |  |  |  |  |  |  |  |
| **Wild animals – monkeys,****other non-human primates** |  |  |  |  |  |  |  |
| **Wild animals - rodents**(such as mouse, rat, squirrel,beaver, etc.) |  |  |  |  |  |  |  |
| **Wild animals – other**(excluding non-human primates and rodents, e.g. wild hooved animals) |  |  |  |  |  |  |  |
| **Captive wildlife**(e.g. zoo animals) |  |  |  |  |  |  |  |
| **Other (specify)** |  |  |  |  |  |  |  |

**Any other comments about animal exposure:**

**2g. MOST LIKELY MODE OF TRANSMISSION, based on the previously reported information**

*(to be determined by investigator based on the previously reported exposure information)*

☐Animal to human transmission

☐Direct- contact (excluding sexual intercourse) transmission from person to person (excluding: mother-to-child during pregnancy or at birth)

☐Healthcare-associated (health care setting / facility or when delivering healthcare)

☐Sexual intercourse

☐Transmission in a laboratory due to occupational exposure

☐Transmission from mother to child during pregnancy or at birth

☐Contact with contaminated surfaces/equipment/material (e.g. bedding, clothing, objects, sex toys??)

☐Parenteral transmission, including intravenous drug use and transfusion

☐Other transmission, specify

☐Unk

MODULE 3. DISEASE SEVERITY, CASE OUTCOME AND LABORATORY INFORMATION

|  |
| --- |
| **3a. DISEASE SEVERITY AND OUTCOME** (Unk = Unknown) |
| **Hospitalization** (select all that apply) | ☐ Yes, for unknown reason☐ Yes, for isolation purposes☐ Yes, due to clinical needs☐ No☐ Unk |   |  |
| **Date of hospital admission** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | ☐Unk |
| **Date of discontinuation of isolation** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | ☐Unk |
| **Date of hospital discharge** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | ☐Unk |
| ☐In hospital at time of form completion |  |
| **ICU or high dependency unit admission?** | ☐Yes ☐No ☐Unk |
| **Date of ICU admission** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | ☐Unk |
| **Date of ICU discharge** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] | ☐Unk |
| ☐In ICU at time of form completion |  |
| **Outcome** | □ Recovered,i*f Yes, specify date symptoms resolved*[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_]□ Still ill□ Dead*if Yes, specify date of death*[\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_]□ Unknown/lost to follow-up |
|
|
|
|

**3b. DIAGNOSTIC/PATHOGEN TESTING** (Unk = Unknown)

**Please select all specimens used for diagnosis of mpox and indicate the overall test result**

**Laboratory identification number**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Specimen type** *(select all that apply)* | **Test performed** *(select all that apply)* | **Result** |
| **Sampling** | ☐Skin lesion material (including swabs of lesion surface, and/or exudate, roofs from more than one lesion)☐Lesion crust☐Blood☐Genital swab☐Oropharyngeal swab☐Urine☐Semen☐Rectal swab☐Cerebrospinal fluid☐Other, *Specify:* |  |  |
|  | ☐Mpox PCR |  |
| [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/ | ☐Orthopoxvirus PCR |  |
| [\_M\_][\_M\_]/[\_D\_][\_D\_] | ☐Clade-specific PCR | ☐Positive |
|  | ☐Sequencing | ☐Negative |
|  | ☐Serology | ☐Inconclusive |
| **Laboratory testing** | ☐Other (specify) | ☐Unk |
| [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/ |  |  |
| [\_M\_][\_M\_]/[\_D\_][\_D\_] |  |  |
| **Genomic characterization undertaken?** | ☐Yes ☐No ☐Unk |
| **If yes, clade:** | ☐Clade I (subclade unknown)☐Clade II (subclade unknown)☐Clade Ia☐Clade Ib☐Clade IIa☐Clade IIb lineages A☐Clade IIb lineages B.1 |
| **If yes, accession number of the sequence uploaded** |  |  |  |
| **to a public database** |  |  |  |
| **Sample stored for future genomic characterization?** |  |  |  |
| **Sample shipped to other laboratory for genomic characterization?** | ☐Yes ☐No ☐Unk |
| **If yes, please specify date** | [\_Y\_][\_Y\_][\_Y\_][\_Y\_]/[\_M\_][\_M\_]/[\_D\_][\_D\_] |
| **Name of laboratory:** |

MODULE 4: FORWARD CONTACT TRACING

|  |
| --- |
| **4. FORWARD TRACING** (Unk = Unknown) |
| **Has the case had any contact (face to face, physical or sexual) with, or stayed in the same household as, one or more persons in the period between onset of symptoms or diagnosis and recovery (all vesicle scabs have fallen off)?**☐Yes ☐No ☐Unk*The following questions should only be asked if patient reports “Yes”* |
|
|
| **How many contacts has the case had since the****onset of symptoms or** **diagnosis?** | **Where did the case have contact (face to face, physical or sexual)** *(select all that apply)* | ☐Household☐Workplace☐School/nursery☐Healthcare setting (including laboratory exposure) |
|
|
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  | ☐Community |
| **How many of the reported contacts are unidentified?***(the case does not have* *their contact details or knows how to reach them.)* |  |  |  | ☐Commercial sex venue☐Social event with sexual contact☐Unk☐Other, specify: |
| **Please list all the contacts below (between first symptom onset to vesicle scab falling off):** |
| **Surname, Name** | **Contact details *(Phone number, email address, home address)*** | **Date and place of contact** | **Type of contact** |
| **1.** |  |  |  |  | ☐Sexual |
|  |  |  |  | ☐Household |
|  |  |  |  | ☐Work setting |
|  |  |  |  | ☐Community |
|  |  |  |  | ☐Other (specify) |
| **2.** |  |  |  |  | ☐Sexual |
|  |  |  |  | ☐Household |
|  |  |  |  | ☐Work setting |
|  |  |  |  | ☐Community |
|  |  |  |  | ☐Other (specify) |
| **3.** |  |  |  |  | ☐Sexual |
|  |  |  |  | ☐Household |
|  |  |  |  | ☐Work setting |
|  |  |  |  | ☐Community |
|  |  |  |  | ☐Other (specify) |
| **4.** |  |  |  |  | ☐Sexual |
|  |  |  |  | ☐Household |
|  |  |  |  | ☐Work setting |
|  |  |  |  | ☐Community |
|  |  |  |  | ☐Other (specify) |
| **5.** |  |  |  |  | ☐Sexual |
|  |  |  |  | ☐Household |
|  |  |  |  | ☐Work setting |
|  |  |  |  | ☐Community |
|  |  |  |  | ☐Other (specify) |
| **6.** |  |  |  |  | ☐Sexual |
|  |  |  |  | ☐Household |
|  |  |  |  | ☐Work setting |
|  |  |  |  | ☐Community |
|  |  |  |  | ☐Other (specify) |

|  |  |  |  |
| --- | --- | --- | --- |
| **7.** |  |  | ☐Sexual |
|  |  | ☐Household |
|  |  | ☐Work setting |
|  |  | ☐Community |
|  |  | ☐Other (specify) |
| **8.** |  |  | ☐Sexual |
|  |  | ☐Household |
|  |  | ☐Work setting |
|  |  | ☐Community |
|  |  | ☐Other (specify) |
| **9.** |  |  | ☐Sexual |
|  |  | ☐Household |
|  |  | ☐Work setting |
|  |  | ☐Community |
|  |  | ☐Other (specify) |

**5. ANY ADDITIONAL INFORMATION**

**6. STATUS OF FORM COMPLETION**

Form completed

□ Yes □ No or partially

If No or partially, reason:

□ Missed

□ Not attempted

□ Not performed

□ Refusal

□ Other, specify: