

Monkeypox Confidential Morbidity Report (CMR) for Healthcare Providers

PATIENT INFORMATION

Last Name	First Name	Date of Birth (mm/dd/yyyy)	Age
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Ethnicity (check one): Hispanic/Latino NOT Hispanic/Latino Unknown **Preferred language:** English Spanish Other _____

Race (check all that apply): White Black/African Amer. Asian Amer. Indian/Alaskan Native Native Hawaii./Pacific Isl. Other: _____

Gender:	MRN:	Patient Location <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Clinic/ ER <input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Other:	Location details (Address)	Patient contact info
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***Vulnerable Population assessment:** Patient Currently... Works and/or Resides in the setting(s) below. **If no concerns, tick here**

Adult Congregate setting Childcare Correctional Facility Specific Facility/Org Name _____ Phone _____

Any other concerns about monkeypox transmission or social services needed (e.g. crowded housing)? _____

Optional: How was this patient MOST LIKELY exposed to monkeypox?

A. Close contact* to a lab confirmed case: No Yes, date exposed: _____ Name and DOB of case if known: _____

Type of contact: Household member Intimate partner Congregate or healthcare setting Other: _____

B. Group gathering: Swimming pool/Sauna Multiple or anonymous sex partners

C. Unknown / Not asked

CLINICAL STATUS OF PATIENT

<i>Is the patient isolating?</i> <input type="checkbox"/> No <input type="checkbox"/> Yes, location: _____ Date patient entered isolation: _____	<i>Able to isolate at home?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>Symptomatic?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If Yes, onset date of rash (mm/dd/yyyy):</i>	<i>Have alternative diagnoses been considered/ ruled out (i.e. syphilis, varicella/varicella zoster, herpes)?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>Has TPOXX been administered? If Yes, date started.</i>
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Significant past medical history:

Immunocompromise: Yes No Unknown Other (specify): _____

Check **all symptoms** exhibited/reported. **DATE of first monkeypox symptom: _____ Have symptoms resolved? No Yes, date: _____

Fever Malaise Headache Sore throat Cough Swollen lymph nodes Rash, date of rash onset: _____

Other: _____

LABORATORY RESULTS

Location of lesions collected:	Number of lesions collected:	Date of Test/Collection:	Results (Attach lab report if available)	Performing lab name:
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MEDICAL PROVIDER CONTACT

Provider Name:	Affiliation:	Location:	Contact information:
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Reporting monkeypox case Requesting monkeypox testing Clinical consultation Possible Exposure/ contact with a case Vaccine request

Other: _____

MONKEYPOX VACCINATION HISTORY

Received one or more doses of monkeypox vaccine? Yes No Date of dose 1: _____ Date of dose 2: _____
 If no, is the patient recommended to receive PEP? Yes No

TRAVEL HISTORY

Did patient travel or live outside county of residence during the incubation period?

Yes No Unknown

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.) / Events / venues attended
<input type="checkbox"/> Domestic <input type="checkbox"/> International <input type="checkbox"/> Unknown			
<input type="checkbox"/> Domestic <input type="checkbox"/> International <input type="checkbox"/> Unknown			
<input type="checkbox"/> Domestic <input type="checkbox"/> International <input type="checkbox"/> Unknown			

SOCIAL HISTORY

Sexual Orientation		Gender of sexual contacts
Known contact with someone with confirmed or suspected monkeypox?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If yes, describe:</i>
Contact with someone with similar symptoms such as a rash or lesion?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If yes, describe:</i>
Patient self-identifies as gay, bisexual, or man who has sex with men (MSM)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If yes, describe:</i>
Patient regularly had close or intimate in-person contact with other men including those who met through an online website, digital application (“app”), at a bar, party, or at a massage parlor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If yes, describe:</i>
Patient has other sexual partners? (i.e., open relationship, non-monogamous relationship, or casual contact)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<i>If yes, describe:</i>

Other Comments:

COMMENTS: