

**NJDOH MPOX INVESTIGATION WORKSHEET**

MR #: \_\_\_\_\_

CDRSS #: \_\_\_\_\_

Demographics										
Patient Last Name			First Name			DOB:		Phone number		
Address					City			Municipality		
Ethnicity	Hispanic	Race	White	Pacific Islander		Sex Assigned at Birth:		Male	Female	
	Non-Hispanic		Black	American Indian or Alaskan Native		Gender:		Male	Female	
	Unknown		Asian	Unknown			Male	Female	Transgender	Other
Occupation					Industry / work setting					
Physician and Facility Information										
Treating physician					Lab contact information					
Name:					Name of lab:					
Facility name:					Point of contact at lab:					
Address:					Address:					
Phone:			Fax:		Phone:			Fax:		
Email:					Email:					
Clinical Status:										
Sign/Symptom	Response			Onset	Additional required information					
Backache	Yes	No	Unk							
Chills	Yes	No	Unk							
Exhaustion	Yes	No	Unk							
Fever ( $\geq 100.4^{\circ}\text{F}$ )	Yes	No	Unk		Highest home temp: _____ F					
					OR Subjective fever only (mark X) _____					
					Measured temp in office: _____ F					
Headache	Yes	No	Unk							
Lymphadenopathy (as assessed by clinician)	Yes	No	Unk		Description (generalized v. localized; location of lymphadenopathy):					
Myalgia	Yes	No	Unk							
Rash	Yes	No	Unk		Description (macular, papular, etc.):					
					Location on body:					
					Rash progression:					

Additional signs/symptoms:

Is the person **vaccinated** for smallpox or mpox? Routine vaccination for smallpox ended in US in 1972. If yes, # of vaccines and when (if they don't know, have the person estimate the year, and request their immunization records).

Yes      No      Unk

Date of Vaccination 1: \_\_\_\_\_ Date of Vaccination 2: \_\_\_\_\_

Is the person **vaccinated** for *varicella* (chickenpox)? If yes, # of vaccines and when (if they don't know, have the person estimate the year, and request their immunization records).

Yes      No      Unk

Date of Vaccination 1: \_\_\_\_\_ Date of Vaccination 2: \_\_\_\_\_

If no: Did patient have a previous varicella infection (chickenpox)?

Yes      No      Unk      Date of infection: \_\_\_\_\_

Pre-existing conditions:

**RISK FACTORS**

<p>In the 21 days before illness onset, did the patient travel outside of New Jersey?</p> <p style="text-align: center;">Yes      No      Unk</p>	<p>Location: _____</p> <p>Date(s): _____ to _____</p>
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<p>In the 21 days before illness onset, did the patient have contact with an animal that could harbor the virus (including animals that are sick or that have been found dead in areas where mpox occurs)?</p> <p style="text-align: center;">Yes      No      Unk</p>	<p>Location of exposure: _____</p> <p>Describe contact: _____</p> <p>Date(s): _____ to _____</p>
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<p>In the 21 days before illness onset, did the patient have contact with any materials, such as bedding, that has been in contact with a sick person or animal?</p> <p style="text-align: center;">Yes      No      Unk</p>	<p>Location of exposure: _____</p> <p>Describe contact: _____</p> <p>Date(s): _____ to _____</p>
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<p>In the 21 days before illness onset, did the patient have exposure to a person diagnosed with mpox, or with a person who has a similar appearing rash?</p> <p style="text-align: center;">Yes      No      Unk</p>	<p>Location of exposure: _____</p> <p>Describe exposure: _____</p> <p>Date(s): _____ to _____</p>
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<p>In the 21 days before illness onset, did the patient handle clinical specimens from a confirmed mpox case?</p> <p style="text-align: center;">Yes      No      Unk</p>	<p>Location of exposure:</p> <p>Describe contact with clinical specimens:</p> <p>PPE donned:</p> <p>Date(s): _____ to _____</p>
<p>Does the patient have sex with men, women, or both?</p> <p style="text-align: center;">Men      Women      Both</p>	<p>Number of partners in 21 days prior to symptom onset: ____</p>

**LABORATORY TESTING**

Test Ordered	Specimen Collection Date	Result	If result is pending, Estimated Date of Result
Dengue	Yes      No		
Malaria	Yes      No		
Measles	Yes      No		
Respiratory Virus Panel	Yes      No		
Typhoid	Yes      No		
Varicella (VZV)	Yes      No		
Syphilis	Yes      No		
Herpes	Yes      No		
Other:			
Other:			
Other:			
Other:			

**CASE NOTES OR OTHER COMMENTS**