

EpiSurv No. _____




Reporting Authority			
Name of Public Health Officer responsible for case _____			
Notifier Identification i			
Reporting source* <input type="radio"/> General Practitioner <input type="radio"/> Hospital-based Practitioner <input type="radio"/> Laboratory <input type="radio"/> Self-notification <input type="radio"/> Outbreak Investigation <input type="radio"/> Other			
Name of reporting source _____		Organisation _____	
Date reported* <input type="text" value="dd/mm/yyyy"/>	Contact phone _____		
Usual GP _____	Practice _____	GP phone _____	
GP/Practice address Number _____ Street _____ Suburb _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
Town/City _____			
Case Identification i			
Name of case* Surname _____ Given Name(s) _____			
NHI number* _____	Email _____		
Current address* Number _____ Street _____ Suburb _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
Town/City _____			
Phone (home) _____	Phone (work) _____	Phone (other) _____	
Case Demography			
Location TA* _____	DHB* _____		
Date of birth* <input type="text" value="dd/mm/yyyy"/>	OR	Age <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years	
Sex* <input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Indeterminate <input type="radio"/> Unknown		
Occupation* _____			
Occupation location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____ Street _____ Suburb _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
Town/City _____			
Alternative location <input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school			
Name _____			
Address Number _____ Street _____ Suburb _____		Post Code _____ <input type="checkbox"/> GeoCode _____	
Town/City _____			
Ethnic group case belongs to* (tick all that apply) i			
<input type="checkbox"/> NZ European	<input type="checkbox"/> Maori	<input type="checkbox"/> Samoan	<input type="checkbox"/> Cook Island Maori
<input type="checkbox"/> Niuean	<input type="checkbox"/> Chinese	<input type="checkbox"/> Indian	<input type="checkbox"/> Tongan
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)	*(specify) _____		

Basis of Diagnosis**CLINICAL CRITERIA** (i)**Fits Clinical Description*** Yes No Unknown**Clinical features****Skin and/or mucosal lesions*** Yes No Unknown

If yes, site of lesions (tick all that apply)*

 Anogenital skin/mucosal lesions Oral skin/mucosal lesions Other skin/mucosal lesions site _____**Proctitis*** Yes No Unknown**Headache*** Yes No Unknown**Fever*** Yes No Unknown**Myalgia*** Yes No Unknown**Backache*** Yes No Unknown**Arthralgia*** Yes No Unknown**Lymphadenopathy*** Yes No Unknown**Other clinical features*** _____**LABORATORY CRITERIA****Detection of monkeypox virus by NAAT from clinical specimen*** Yes No Not Done Awaiting Results**EPIDEMIOLOGICAL CRITERIA (refer to case definition)** (i)**Did the case have contact with a confirmed or probable case of monkeypox in the 21 days prior to onset?*** Yes No Unknown

If contact was in New Zealand, EpiSurv number of case* _____

Did the case travel to an area where monkeypox is endemic in the 21 days prior to onset?* Yes No Unknown**Is the case in a priority group for testing?*** Yes No Unknown**CLASSIFICATION*** Under investigation Probable Confirmed Not a case (i)**Clinical Course and Outcome****Date of onset***dd/mm/yyyy  Approximate Unknown**Hospitalised*** Yes No Unknown**Date hospitalised***dd/mm/yyyy  Unknown**Hospital*** _____**Died*** Yes No Unknown**Date died***dd/mm/yyyy  Unknown**Was this disease the primary cause of death?*** Yes No Unknown

If no, specify the primary cause of death* _____

Outbreak Details**Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*** Yes

If yes, specify Outbreak No.* _____

Risk Factors

Attendance at school, pre-school or childcare* Yes No Unknown

Is the case a health care worker?* Yes No Unknown

Was the case overseas in the 21 days prior to onset?* Yes No Unknown

If yes, date arrived in New Zealand*

dd/mm/yyyy 

Specify countries visited* (from most recent to least recent)

Country/Region	Date Entered	Date Departed
Last: _____	dd/mm/yyyy 	dd/mm/yyyy 
Second Last: _____	dd/mm/yyyy 	dd/mm/yyyy 
Third Last: _____	dd/mm/yyyy 	dd/mm/yyyy 

Sexual behaviour (tick all that apply)

Men who have sex with women (MSW)

Women who have sex with men (WSM)

Men who have sex with men (MSM)

Women who have sex with women (WSW)

Other (specify) _____

Has the case had sexual contact with more than one person or someone for whom they have no contact details in the past 21 days? Yes No Unknown

Other risk factors* _____

RISK FACTORS FOR SEVERE DISEASE

Does the case have an immunodeficiency?* Yes No Unknown

If yes, indicate the cause (tick all that apply)*

Due to disease

Due to medication

If female, is the case pregnant or in the post-partum period?* Yes No Unknown

If yes, number of weeks* _____ weeks

Post-partum (< 6 weeks)

Unknown

Source

What was the source of the virus?* Overseas acquired Locally acquired Unknown

If acquired overseas, specify country* _____

Protective Factors

Was the case immunised with smallpox vaccine prior to onset?* Yes No Unknown

If yes, how many doses did the case receive prior to onset?*

One dose

Two or more doses

Unknown

Specify date of last vaccination*

dd/mm/yyyy 

How was vaccination status confirmed?*

Patient/Caregiver recall

Documented

NA

Unknown

Management**CASE MANAGEMENT**

Was the case advised to isolate for an appropriate period? Yes No Unknown

If yes, isolation start date

dd/mm/yyyy 

Isolation end date

dd/mm/yyyy 

CONTACT MANAGEMENT**Number of contacts identified**

Household contacts _____

Health care workers _____

Sexual contacts (non-household) _____

Other contacts _____

Comments*

[Empty comment box]