State of California—Health and Human Services Agency

California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

DISEASE BEING REPORTED → Monkeypox

Patient Name - Last Name	***First Name***	***MI***	***Ethnicity (check one)*** ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown
Home Address: Number, Street		***Apt./Unit No.***	***Race (check all that apply)*** ☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian *(check all that apply)* ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other *(specify)*: _____ ☐ Pacific Islander *(check all that apply)* ☐ Native Hawaiian ☐ Samoan ☐ Guamanian ☐ Other *(specify)*: _____ ☐ White ☐ Other *(specify)*: _____ ☐ Unknown
City	***State***	***ZIP Code***	
Home Telephone Number	***Cell Telephone Number***	***Work Telephone Number***	
Email Address	***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____		
Birth Date (mm/dd/yyyy)	***Age*** ☐ Years ☐ Months ☐ Days	***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____	
Pregnant? ☐ Yes ☐ No ☐ Unknown	***Est. Delivery Date (mm/dd/yyyy)***	***Country of Birth***	
Occupation or Job Title	***Occupational or Exposure Setting (check all that apply):*** ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____		
Date of Onset (mm/dd/yyyy)	***Date of First Specimen Collection (mm/dd/yyyy)***	***Date of Diagnosis (mm/dd/yyyy)***	***Date of Death (mm/dd/yyyy)***
Reporting Health Care Provider	***Reporting Health Care Facility***		**REPORT TO:** Solano County Public Health Communicable Disease Program 275 Beck Avenue, MS 5-240 Fairfield, CA 94533 Phone (707) 784-8001 FAX (707) 784-5927 (Obtain additional forms from your local health department.)
Address: Number, Street		***Suite/Unit No.***	
City	***State***	***ZIP Code***	
Telephone Number	***Fax Number***		
Submitted by	***Date Submitted (mm/dd/yyyy)***		
Laboratory Name	***City***	***State***	***ZIP Code***

Requesting a consultation from Solano Public Health? Please fill out contact information below.	
Name:	Phone number:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

Monkeypox Screening Worksheet

Patient Information		
Last Name	*First Name*	*MRN:*
Location details (Address)	*Patient contact info*	

Disposition (Suspect monkeypox case: new characteristic rash OR meets one of the epidemiologic criteria and has a high clinical suspicion for monkey pox Case Definitions† for Use in the 2022 Monkeypox Response | Monkeypox | Poxvirus | CDC

☐ Seen in ED ☐ Admitted ☐ Home ☐ Hotel	Date for Admission: Treatment: Date Treatment Initiated:
Provider Notes & Comments:	

CLINICAL INFORMATION		
Symptomatic? ☐ Yes ☐ No ☐ Unknown	*If Yes, onset date of symptoms (mm/dd/yyyy)*	*Have alternative diagnoses been considered/ ruled out (i.e. syphilis, varicella/varicella zoster, herpes)?* ☐ Yes ☐ No ☐ Unknown

Signs and Symptoms	**Yes**	**No**	**Unk**	**If Yes, Specify as Noted**	
Fever (>100.4°F or 38°C) or Chills				*Onset Date of Fever or Chills (mm/dd/yyyy)*	*If Fever Measured, Highest Temperature (°F or °C)*
Lymphadenopathy				*Describe location*	
Malaise/ exhaustion				*Describe*	
Other				*Specify other symptoms*	

Other Signs / Symptoms

Rash		***Comments/ notes***
General description of rash	*Check all that apply* ☐ Macular ☐ Papular ☐ Vesicular ☐ Pustular	
Detailed appearance	☐ Deep-seated ☐ Well-circumscribed ☐ Umbilicated ☐ Other:	
Distribution	☐ Generalized ☐ Localized	
Location	☐ Tongue/mouth/ oropharynx ☐ Face ☐ Hands ☐ Feet ☐ Genitalia ☐ Perianal ☐ Other (describe) ☐ Other (describe)	*Progression of lesions (describe where started, and how spread)*

Monkeypox Screening Worksheet

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	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
☐ Domestic ☐ International ☐ Unknown					
☐ Domestic ☐ International ☐ Unknown					
☐ Domestic ☐ International ☐ Unknown					

Vaccination History	
☐JYNNEOS	Date(s) Received:
☐ ACAM2000	Date(s) Received:
Additional vaccination history/comments:	

SOCIAL HISTORY		
Sexual Orientation		Gender of sexual contacts
Known contact with someone with confirmed or suspected monkeypox?	☐Yes ☐ No ☐ Unknown	*If yes, describe:*
Contact with someone with similar symptoms such as a rash or lesion?	☐Yes ☐ No ☐ Unknown	*If yes, describe:*
Patient self-identifies as gay, bisexual, or man who has sex with men (MSM)?	☐Yes ☐ No ☐ Unknown	*If yes, describe:*
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?	☐Yes ☐ No ☐ Unknown	*If yes, describe:*
Patient has other sexual partners? (i.e., open relationship, non-monogamous relationship, or casual contact)	☐Yes ☐ No ☐ Unknown	*If yes, describe:*
Other Comments:		

SPECIMEN INFORMATION		
Where is specimen(s) being tested? (e.g., Quest, Labcorp, VRDL…)	*Date of Collection:*	*Time of Collection:*
COMMENTS:		