Mpox Confidential Morbidity Report (CMR) for Healthcare Providers

PATIENT INFORMATION

Last Name	*First Name*	*Date of Birth (mm/dd/yyyy)*	*Age*

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*	*Location details (Address)*	*Patient contact info*
		☐ Home ☐ Outpatient Clinic/ ER ☐ Hospital inpatient ☐ Other:		

***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 mpox transmission or social services needed (e.g. crowded housing)? _____

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

☐ **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

Is the patient isolating?	*Able to isolate at home?*	*Symptomatic?*	*If Yes, onset date of rash (mm/dd/yyyy):*	*Have alternative diagnoses been considered/ ruled out (i.e. syphilis, varicella/varicella zoster, herpes)?*
☐ No ☐ Yes, location: _____ Date patient entered isolation:_____	☐ Yes ☐ No ☐ Unknown	Yes ☐ No ☐ Unknown		☐ Yes ☐ No ☐ Unknown *Has TPOXX been administered? If Yes, date started.*

Significant past medical history:

Immunocompromise**:** ☐ Yes ☐ No ☐ Unknown Other (specify): _____

Check **all symptoms** exhibited/reported. **DATE of first mpox 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:*

MEDICAL PROVIDER CONTACT

Provider Name:	*Affiliation:*	*Location:*	*Contact information:*

☐ Reporting mpox case ☐ Requesting mpox testing ☐ Clinical consultation ☐ Possible Exposure/ contact with a case ☐ Vaccine request

☐ Other_____

MPOX VACCINATION HISTORY

Received one or more doses of mpox 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**
☐ Domestic ☐ International ☐ Unknown			
☐ Domestic ☐ International ☐ Unknown			
☐ Domestic ☐ International ☐ Unknown			

SOCIAL HISTORY

Sexual Orientation		Gender of sexual contacts
Known contact with someone with confirmed or suspected mpox?	☐ 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:		

COMMENTS: