

Please print

1. State [] [] 2. Case # _____

Circled numbers indicate the minimum required fields. Every attempt should be made to at least complete the circled items.

3. CASE NAME: Last First Middle Suffix Nickname/Alias

4. ADDRESS: Street Address, Apt # City State Zip Code

5. TELEPHONE: Home: Area Code Number Work: Area Code Number Other: Area Code Number

CASE INFORMATION

6. DATE OF BIRTH: Month Day Year
7. AGE: AGE UNIT: Years Months Day
9. GENDER: Male Female
10. ETHNICITY: Hispanic Non-Hispanic
11. RACE (Check all that apply): Am. Indian/Alaska Native Asian Black/African Am. White Native Hawaiian/Pacific Islander Unknown
12. COUNTRY OF BIRTH:

VACCINATION AND MEDICAL HISTORY, CON'T

29. DURING THE PAST MONTH, ANY PRESCRIBED IMMUNOCOMPROMISING OR IMMUNOMODULATING MEDICATIONS INCLUDING STEROIDS: Yes No Unknown
IF YES, PLEASE SPECIFY:
30. FOR WHAT MEDICAL CONDITION:

REPORTING SOURCE AND INFORMATION

13. DATE FIRST REPORTED TO PUBLIC HEALTH: Month Day Year
14. REPORTED BY: Name/Institution
15. REPORTED BY PHONE NUMBER: Area Code Number

CURRENT ILLNESS

31. HAS THE PATIENT HAD A FEVER AS PART OF THIS ILLNESS IN THE 4 DAYS PRIOR TO RASH ONSET? Yes No Unknown
IF YES, ESTIMATED DATE OF FEVER ONSET: Month Day Year

16. FORM INITIATED BY: (INTERVIEWER NAME) Last First Middle
17. INTERVIEW DATE: Month Day Year

32. WAS TEMPERATURE MEASURED WITH A THERMOMETER? Yes No Unknown

33. MAXIMUM TEMPERATURE: F° / C° (Circle)

34. DATE OF MAXIMUM FEVER: Month Day Year

35. DATE OF RASH ONSET: Month Day Year

18. INFORMATION PROVIDED BY: Informant: Last First Middle

36. COUGH WITH RASH/ILLNESS? Yes No Unknown

37. DATE OF COUGH ONSET? Month Day Year

19. TELEPHONE NUMBER OF INFORMANT: Area Code Number

38. SYMPTOMS DURING THE 4 DAYS PRECEDING RASH ONSET (Check all the apply): Headache: Yes No Unknown Backache: Yes No Unknown Chills: Yes No Unknown Vomiting: Yes No Unknown Other (e.g., abdominal pain, delirium) Specify:

20. PRIMARY INTERVIEW LANGUAGE SPOKEN:

VACCINATION AND MEDICAL HISTORY

21. SMALLPOX VACCINATION PRIOR TO THIS OUTBREAK: Yes No Unknown IF YES, NUMBER OF DOSES: One More than one

39. DISTRIBUTION OF LESIONS: Generalized, predominantly face and distal extremities (centrifugal) Generalized, predominantly trunk (centripetal) Localized, not generalized Other, specify:

22. IF KNOWN: AGE (YEARS) OR YEAR OF LAST DOSE

23. SMALLPOX VACCINATION SCAR PRESENT: Yes No Unknown

24. SMALLPOX VACCINATION DURING THIS OUTBREAK: Yes No Unknown

40. CLINICAL TYPE OF SMALLPOX: Ordinary/Classic type: Discrete lesions Semi-confluent - Face only Confluent - Face and other site Variola sine eruptione Modified type Flat type Hemorrhagic type: Early Late

IF YES, DATE OF VACCINATION: Month Day Year

25. VACCINE "TAKE" RECORDED AT 7 DAYS (6-8 DAYS): Yes No Unknown IF YES, RESULT: Major None Equivocal Unknown

26. IF NOT VACCINATED DURING THIS OUTBREAK, GIVE REASON: Patient refusal Patient forgot Medical contraindication Unaware of need to be vaccinate Vaccination site unavailable/unknown Other, specify:

CLINICAL TYPES OF SMALLPOX:

Ordinary/Classic type: Raised, pustular lesions with 3 sub-types: Discrete: Areas of normal skin between pustules, even on face Semi-confluent: Confluent rash on face, discrete elsewhere Confluent: Confluent rash on face and forearms Modified type: Like ordinary type but with an accelerated, less severe course Variola sine eruptione: fever without rash caused by variola virus, serological confirmation required. This condition is rare; epidemiological significance is considered to be limited. Flat type: Pustules remain flat; usually confluent or semi-confluent Hemorrhagic type: Widespread hemorrhages in skin and mucous membranes Early: With purpuric rash Late: With hemorrhage into base pustules

27. IF FEMALE, PREGNANT: Yes No Unknown

28. PRE-EXISTING IMMUNOCOMPROMISING MEDICAL CONDITIONS (i.e., LEUKEMIA, OTHER CANCERS, HIV/AIDS): Yes No Unknown IF YES, PLEASE SPECIFY:

Public reporting burden of this collection of information is estimated to average ___ minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0008).

Form 1: Smallpox Post-Event Surveillance Form
Please print

State

Case # _____

CLINICAL COURSE	
41. DATE LAST SCAB FELL OFF: OR CHECK IF UNKNOWN <input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year
42. DID THE PATIENT DEVELOP ANY COMPLICATIONS: IF YES, CHECK ALL THAT APPLY:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Skin, infected lesions/abscesses	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Corneal ulcer or keratitis	<input type="checkbox"/> Hemorrhagic
<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Shock
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bacterial sepsis
<input type="checkbox"/> Other, specify: _____	
43. ANTIVIRAL MEDICATION (CIDOFOVIR): IF YES, DATE CIDOFOVIR STARTED:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year
DURATION: _____ DAYS	
44. OTHER ANTIVIRAL MEDICATIONS GIVEN:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, SPECIFY: _____	

LABORATORY, CON'T			
VARIOLA SPECIFIC TESTS			
TEST	DATE	RESULT	WHERE
52. VARIOLA PCR FROM CLINICAL SPECIMEN	<input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> No <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify:
53. VARIOLA CULTURE WITH VARIOLA PCR CONFIRMATION	<input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> No <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify:

CLINICAL OUTCOME	
45. WAS CASE ADMITTED TO HOSPITAL?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, HOSPITAL NAME: _____	
HOSPITAL LOCATION: _____	
DATE ADMITTED:	DATE DISCHARGED:
<input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year	<input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year
46. WAS CASE ADMITTED/TRANSFERRED TO 2 ND HOSPITAL?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, HOSPITAL NAME: _____	
HOSPITAL LOCATION: _____	
DATE ADMITTED:	DATE DISCHARGED:
<input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year	<input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year
47. DID THE PATIENT DIE FROM SMALLPOX ILLNESS OR ANY SMALLPOX COMPLICATIONS?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, DATE OF DEATH:	<input type="text"/> / <input type="text"/> / <input type="text"/> Month Day Year

VACCINIA SPECIFIC TEST			
TEST	DATE	RESULT	WHERE
54. VACCINIA PCR	<input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> No <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify:
55. OTHER TESTING PERFORMED:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
IF YES, SPECIFY: _____			

EPIDEMIOLOGIC	
56. TRANSMISSION SETTING:	<input type="checkbox"/> Athletics <input type="checkbox"/> College <input type="checkbox"/> Community <input type="checkbox"/> Daycare <input type="checkbox"/> Dr. Office <input type="checkbox"/> Correctional facility <input type="checkbox"/> Home <input type="checkbox"/> Hospital <input type="checkbox"/> Int'l travel <input type="checkbox"/> Military <input type="checkbox"/> School <input type="checkbox"/> Place of worship <input type="checkbox"/> Work <input type="checkbox"/> Other <input type="checkbox"/> Unknown
IF Other, specify: _____	

LABORATORY	
48. WAS SPECIMEN COLLECTED FOR TESTING:	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown
49. WAS LAB TESTING DONE FOR SMALLPOX:	<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF QUESTIONS 48 AND 49 ARE "NO" OR "UNKNOWN" THEN GO TO QUESTION 56.	
* Information on specimen collection and testing can be found in the patient's medical chart or provided by the laboratory	

CASE CLASSIFICATION	
57. DOES THIS CASE MEET THE CLINICAL CASE DEFINITION:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
58. IS THIS CASE EPIDEMIOLOGICALLY LINKED TO A CONFIRMED CASE:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, NAME/CASE #, IF KNOWN: _____	
59. IS THIS CASE LABORATORY-CONFIRMED:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
IF YES, BY WHAT METHOD:	<input type="checkbox"/> PCR <input type="checkbox"/> Culture/PCR
60. WHAT IS THE CASE CLASSIFICATION:	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect
61. IF NOT SMALLPOX, SPECIFY FINAL DIAGNOSIS: _____	

ORTHOPOX GENERIC TESTS			
TEST	DATE	RESULT	WHERE
50. ORTHOPOX PCR	<input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> Blood <input type="checkbox"/> No <input type="checkbox"/> Crust <input type="checkbox"/> CSF <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify:
51. ELECTRON MICROSCOPY (EM)	<input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY SPECIMEN TYPE: <input type="checkbox"/> Skin lesion <input type="checkbox"/> No <input type="checkbox"/> Other, specify <input type="checkbox"/> Unknown	<input type="checkbox"/> Pox Virus Identified <input type="checkbox"/> Pox Virus Not Identified <input type="checkbox"/> Indeterminate	<input type="checkbox"/> CDC <input type="checkbox"/> DOD <input type="checkbox"/> State <input type="checkbox"/> Local <input type="checkbox"/> Other Lab Specify:

Smallpox Clinical Case Definition: An illness with acute onset of fever $\geq 101^{\circ}\text{F}$ followed by a rash characterized by firm, deep seated vesicles or pustules in the same stage of development without other apparent cause.

Laboratory Criteria for Confirmation*: Polymerase chain reaction (PCR) identification of variola DNA in a clinical specimen; OR Isolation of smallpox (variola) virus from a clinical specimen (Level D laboratory only).
Note: Orthopox PCR and negative stain electron microscopy (EM) identification of a pox virus in a clinical specimen suggest orthopox virus infection but are not diagnostic of variola and/or vaccinia. (Level D laboratory or approved Level C laboratory)

*Level D laboratories include the CDC and USAMRIID. Initial confirmation of a smallpox outbreak requires testing in a Level D laboratory. Level C laboratories will assist with testing of clinical specimens following initial confirmation of an outbreak by CDC.

Smallpox Case Classification:
Confirmed case = A case of smallpox that is laboratory confirmed, OR a case that meets the clinical case definition that is epidemiologically linked to a laboratory confirmed case.
Probable case = A case that meets the clinical case definition, OR a case that has an atypical presentation that has an epidemiological link to a confirmed case of smallpox. Atypical presentations of smallpox are: a) hemorrhagic type, b) flat, type not appearing as typical vesicles nor progressing to pustules and variola sine eruptione.
Suspect case = A case with a febrile rash illness with fever preceding development of rash by 1-4 days.