

Date:		Reporting Facility:	
Patient Name:		Patient DOB:	
Patient Address:		County:	State: Zip:
Patient MRN:	Evaluating Clinician:		Clinician Phone/Fax:
Consider monkeypox in the differential diagnosis of patients with a characteristic* rash:			
A) Does the patient have a rash?		YES	NO
		Rash onset date: ___/___/___	
B) Rash characteristics:		YES	NO
Deep-seated, firm, discrete, well-circumscribed			
Similar development stage of lesions on one area or body part			
Photographs available of lesions			
Body location(s) of lesions: _____		Estimated # of lesions: _____	
C) Other symptoms (check all that apply):		First symptom onset date: ___/___/___	
<input type="checkbox"/> Fever (if measured: Highest temp: _____) <input type="checkbox"/> Malaise, fatigue, or exhaustion <input type="checkbox"/> Myalgia (muscle aches or pains) <input type="checkbox"/> Cough or sore throat <input type="checkbox"/> Headache		<input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Rectal pain or swelling <input type="checkbox"/> Other: _____ _____ _____	
		D) Other testing completed (select all): <input type="checkbox"/> Syphilis <input type="checkbox"/> pos <input type="checkbox"/> neg <input type="checkbox"/> pending <input type="checkbox"/> Herpes <input type="checkbox"/> pos <input type="checkbox"/> neg <input type="checkbox"/> pending <input type="checkbox"/> Other: _____ <input type="checkbox"/> pos <input type="checkbox"/> neg <input type="checkbox"/> pending	
E) Epi Criteria – Within the last 21 days, has the person (select all that apply):			
<input type="checkbox"/> Had close or intimate in-person contact with someone diagnosed with monkeypox, or with someone with a rash? <input type="checkbox"/> Had close or intimate in-person contact with anyone in a social network experiencing monkeypox outbreaks? <input type="checkbox"/> Traveled to a location with known monkeypox transmission? <input type="checkbox"/> Had contact with a dead or live wild animal or exotic pet that is an endemic species for monkeypox?		Dates and description of travel and/or contacts: 	
F) Past medical history – (select all that apply):			
<input type="checkbox"/> Immune compromising condition (such as HIV, cancer, immune suppressing medications) <input type="checkbox"/> Other underlying condition(s): _____ <input type="checkbox"/> Pregnant <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Has a high risk household member/contact		Has the person been vaccinated for smallpox or monkeypox? <input type="checkbox"/> Yes (if known: Date: _____) <input type="checkbox"/> No <input type="checkbox"/> Unknown	

IF MONKEYPOX IS SUSPECTED, IMMEDIATELY:

- Mask and isolate the patient (in negative air pressure room when possible); Ensure providers don PPE as appropriate:** [Infection Control: Healthcare Settings | Monkeypox | Poxvirus | CDC](#)
- Collect specimens for possible monkeypox testing.**
 - Collect a minimum of 2 lesion swabs or scabs (maximum of 4) – rub dry synthetic swab firmly over lesion.
 - Put each in separate sterile container – dry or <3ml VTM (**not** UTM). Label each with name, DOB, body site.
 - Place specimens in freezer unless delivering within 24 hours – can refrigerate if delivered by 24 hours.
- Collect any other specimens to test for appropriate differential diagnoses through regular channels.**
- Contact your local health jurisdiction to get approval for testing and guidance for shipping.**

LHJ Name:

LHJ contact information: Confidential Fax Line: (509) 381-3526 Reporting Line: (800) 535-5016 ext. 541

DO NOT SHIP SUSPECTED MONKEYPOX SPECIMENS WITHOUT PRIOR APPROVAL OF LOCAL HEALTH JURISDICTION.