Smallpox

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Investigation Information

*indicates required fields

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial

Street Address

City	County	State	Zip
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy

Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	County	State	Zip
		West Virginia	

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	Age	Age Units
		○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Patient Demographic Information cont.

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native*
☐ *Asian*
☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White*
☐ *Unknown*
☐ *Failure to report race/missing race*
☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy		**Date of diagnosis** mm/dd/yyyy	
Was patient hospitalized for this disease? ○ *Yes* ○ *No* ○ *Unknown*	**Name of Hospital**	**Date of Admission** mm/dd/yyyy	**Date of Discharge** mm/dd/yyyy
Was the case admitted/transferred to 2nd hospital? ○ *Yes* ○ *No* ○ *Unknown*	**Name of Hospital**	**Date of Admission** mm/dd/yyyy	**Date of Discharge** mm/dd/yyyy
Patient outcome from smallpox illness or any smallpox complications: ○ *Died* ○ *Survived* ○ *Unknown*		**Date of Death** mm/dd/yyyy	
During the past month, any prescribed immunocompromising or immunomodulating medications including steroids ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, specify**	**For what medical condition**	
Pre-existing immunocompromising medical conditions (i.e., Leukemia, other cancers, HIV/AIDS) ○ *Yes* ○ *No* ○ *Unknown*		**If Yes, specify**	
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 onset** mm/dd/yyyy	
Was the temperature measured with a thermometer ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, Maximum Temperature**	**If Yes, Date of maximum fever** mm/dd/yyyy	
Date of rash onset mm/dd/yyyy	**Cough with Rash/illness** ○ *Yes* ○ *No* ○ *Unknown*	**Date of cough onset** mm/dd/yyyy	

Outcome and Clinical Information cont.

Symptoms during the 4 days preceding rash onset (check all that apply)

Headache	Backache	Chills	Vomiting
○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*

Specify other symptoms during the 4 days preceding rash onset

Distribution of lesions

○ *Generalized, predominantly face and distal extremities (centrifugal)*
○ *Generalized, predominantly trunk (centripetal)*
○ *Localized, not generalized*
○ *Other, specify*_____

Clinical Type of Smallpox

○ *Ordinary/Classic type* ○ *Variola sine eruptions* ○ *Modified type* ○ *Flat type* ○ *Haemorrhagic type*

If Ordinary/Classic type, specify

○ *Discrete lesions* ○ *Semi-confluent - Face only* ○ *Confluent - Face and other site*

If Haemorrhagic type, specify

○ *Early* ○ *Late*

Date last scab fell off

mm/dd/yyyy

Did the patient develop any complications

○ *Yes* ○ *No* ○ *Unknown*

If Yes to complications

(Check all that apply)

☐ *Skin, infected lesions/abscesses* ☐ *Corneal ulcer or keratitis* ☐ *Encephalitis* ☐ *Arthritis*
☐ *Pneumonia* ☐ *Haemorrhagic Shock* ☐ *Bacterial sepsis* ☐ *Other, specify*_____

Antiviral medication (Cidofovir)	If Yes, date Cidofovir started	Duration:	Other antiviral medications given	If Yes, specify
○ *Yes* ○ *No* ○ *Unknown*	mm/dd/yyyy	days	○ *Yes* ○ *No* ○ *Unknown*	

Reporting Source

Last Name	First Name

Phone	Ext.	Fax
###-###-####		###-###-####

Facility

Address

City	State	Zip
	West Virginia	

E-mail

Provider with Further Patient Information

Last Name	First Name	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
Address		
City	**State** West Virginia	**Zip**

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy
Investigator	**Date public health investigation began** mm/dd/yyyy	**Health Department** / **Phone** ###-###-####
Ext.		
Investigation ID	**Part of an Outbreak?** ○ *Yes* ○ *No* ○ *Unknown*	**Outbreak Name** / **Lost to follow-up?** ○ *Yes* ○ *No*

○ *Check if epi-linked to another case and complete information below*

Last Name of Epi-linked Case	First Name	DOB mm/dd/yyyy
County	**Onset Date** mm/dd/yyyy	
Date First Reported to a Health Department mm/dd/yyyy	**Reported By** Name/Institution	**Phone Number**

Vaccine Information

Smallpox vaccination prior to this outbreak	If Yes, number of doses	If known, Age (years)	If known, year of last dose
○ *Yes* ○ *No* ○ *Unknown*	○ *One* ○ *More than one*		
Smallpox vaccination scar present ○ *Yes* ○ *No* ○ *Unknown*	**Smallpox vaccination during this outbreak** ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, date of vaccination** mm/dd/yyyy	
Vaccine "Take" recorded at 7 days (6-8 days) ○ *Yes* ○ *No* ○ *Unknown*	**If Yes, Result** ○ *Major* ○ *Equivocal* ○ *None* ○ *Unknown*	**If Female, Pregnant** ○ *Yes* ○ *No* ○ *Unknown*	

If not vaccinated, what was the reason?

○ *Patient refusal* ○ *Medical Contraindication* ○ *Vaccination site unavailable/unknown*
○ *Patient forgot* ○ *Unaware of need to be vaccinated* ○ *Other (specify):*_____

Epidemiologic Information

Transmission Setting

○ *Athletics* ○ *College* ○ *Community* ○ *Correctional Facility* ○ *Daycare*
○ *Doctor's Office* ○ *Home* ○ *Hospital* ○ *International Travel* ○ *Military*
○ *Place of Worship* ○ *School* ○ *Work* ○ *Unknown* ○ *Other, specify*_____

Laboratory Information

Was specimen collected for testing
○ *Yes* ○ *No* ○ *Unknown*

Was lab testing done for smallpox
○ *Yes* ○ *No* ○ *Unknown*

Orthopox Generic Tests

Orthopox PCR Test

Orthopox PCR Test?
○ *Yes* ○ *No* ○ *Unknown*

Date
mm/dd/yyyy

Specimen Type
○ *Skin Lesion* ○ *Crust* ○ *Oropharyngeal* ○ *Blood* ○ *CSF* ○ *Unknown* ○ *Other, specify*_____

Result
○ *Positive* ○ *Negative* ○ *Unknown*

Where
○ *CDC* ○ *DOD* ○ *State* ○ *Local* ○ *Other Lab, specify*_____

Electron Microscopy Test

Electron Microscopy (EM) Test?
○ *Yes* ○ *No* ○ *Unknown*

Date
mm/dd/yyyy

Specimen Type
○ *Skin Lesion* ○ *Unknown* ○ *Other, specify*_____

Result
○ *Pox Virus Identified* ○ *Pox Virus Not Identified* ○ *Indeterminate*

Where
○ *CDC* ○ *DOD* ○ *State* ○ *Local* ○ *Other Lab, specify*_____

Variola Specific Tests

Variola PCR from Clinical Specimen

Variola PCR from Clinical Specimen?
○ *Yes* ○ *No* ○ *Unknown*

Date
mm/dd/yyyy

Specimen Type
○ *Skin Lesion* ○ *Crust* ○ *Oropharyngeal* ○ *Blood* ○ *CSF* ○ *Unknown* ○ *Other, specify*_____

Result
○ *Positive* ○ *Negative* ○ *Unknown*

Where
○ *CDC* ○ *DOD* ○ *State* ○ *Local* ○ *Other Lab, specify*_____

Variola Culture with Variola PCR Confirmation

Variola Culture with Variola PCR Confirmation?
○ *Yes* ○ *No* ○ *Unknown*

Date
mm/dd/yyyy

Specimen Type
○ *Skin Lesion* ○ *Crust* ○ *Oropharyngeal* ○ *Blood* ○ *CSF* ○ *Unknown* ○ *Other, specify*_____

Result
○ *Positive* ○ *Negative* ○ *Unknown*

Where
○ *CDC* ○ *DOD* ○ *State* ○ *Local* ○ *Other Lab, specify*_____

Laboratory Information cont.

Vaccinia Specific Test

Vaccinia PCR

Vaccinia PCR?

○ *Yes* ○ *No* ○ *Unknown*

Date
mm/dd/yyyy

Specimen Type

○ *Skin Lesion* ○ *Crust* ○ *Oropharyngeal* ○ *Blood* ○ *CSF* ○ *Unknown* ○ *Other, specify*_____

Result

○ *Positive* ○ *Negative* ○ *Unknown*

Where

○ *CDC* ○ *DOD* ○ *State* ○ *Local* ○ *Other Lab, specify*_____

Was other laboratory testing done?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, Specify

Laboratory Name	**Phone** ###-###-####	**Ext.**	**Fax Number** ###-###-####

Address

State:
West Virginia

Zip:

Describe public health action taken