VPD-18

Revised August 2017

Identification Number ______
Person Completing Form ______
Date of Contact with Case ______
Today's Date (mo/da/yr) ______

# WORKSHEET: EVALUATING PATIENTS FOR SMALLPOX

## PATIENT INFORMATION

**Name:** ______
LAST FIRST MIDDLE INITIAL

**Date of Birth:** ___/___/___ **Age:** ___ **Sex:** ☐ Male ☐ Female

**Telephone:**
Home ______ Other ______

**Address:** ______
CITY STATE ZIP

**Where is the patient now?** ☐ Home ☐ Doctor's Office
☐ Emergency Room *(if checked, continue below)*
☐ Hospital *(if checked, continue below)*
☐ Other *(specify)* ______

Hospital Name ______
City/State ______
Admission Date ___/___/___ Discharge Date ___/___/___
Hospital Telephone Number ( ) ______

**Race:** ☐ White ☐ Black ☐ Asian ☐ Other **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic **Country of Birth:** ______

## PROVIDER INFORMATION

**Name:** ______
**Patient Population:** ☐ Adult ☐ Peds ☐ Both
**Specialty:** ______
**Telephone:**
Type ______ ( ) ______
Type ______ ( ) ______
**E-mail Address:** ______

**Name:** ______
**Patient Population:** ☐ Adult ☐ Peds ☐ Both
**Specialty:** ______
**Telephone:**
Type ______ ( ) ______
Type ______ ( ) ______
**E-mail Address:** ______

## CLINICAL INFORMATION

### PRODROME / SYMPTOMS 1-4 DAYS BEFORE RASH ONSET

Did the patient have a fever and other illness 1-4 days before rash onset? ☐ Yes ☐ No ☐ Unknown

Date of prodrome onset ___/___/ 200_

Date of first fever ≥101° F: ___/___/___

What was the highest temperature? ______° F or ______° C

On what date? ___/___/___

Check all features of the prodrome that apply:
☐ No/Mild prodrome (<1 day)
☐ Headache
☐ Backache
☐ Chills
☐ Vomiting
☐ Abdominal pain
☐ Sore throat*
☐ Other *(specify)* ______

*In infants, this may manifest as drooling or refusing to eat or drink.

Was the patient toxic or seriously ill? ☐ Yes ☐ No ☐ Unknown

Was the patient able to do most normal activities? ☐ Yes ☐ No ☐ Unknown

### RASH

Date of rash onset ___/___/ 200_

Was the rash acute (sudden) in onset? ☐ Yes ☐ No ☐ Unknown

Was a black scar (eschar) present before or at the time of appearance of the rash? ☐ Yes ☐ No ☐ Unknown

Is the rash *generalized* (i.e., multiple parts of the body) or *focal* (i.e., only one part of the body)? ☐ Generalized ☐ Focal

Where on the body were the first lesions noted?
☐ Face
☐ Trunk
☐ Inside the mouth
☐ Other *(specify)* ______
☐ Arms
☐ Legs
☐ Unknown

Since rash onset, where on the body was the rash most dense?
☐ Trunk
☐ Face or scalp
☐ Distal extremities (arms, legs)
☐ Equally distributed everywhere
☐ Other *(describe)* ______

Are there any lesions on the palms or soles? ☐ Yes ☐ No ☐ Unknown

What kind of lesions does the patient have now? *(check all that apply)*
☐ Macules (flat spots)
☐ Papules (solid bumps)
☐ Vesicles (fluid-filled blisters)
☐ Pustules (blisters filled with pus)
☐ Crusts
☐ Other ______

If more than one kind of lesion, which kind of lesion is now the most common? ______

Are the lesions now:
☐ Superficial (on top of the skin)
☐ Deep (feel embedded deeply in the skin)
☐ Neither *(describe)* ______

How many lesions are present? (in total) ______

If no precise count is available, please estimate:
☐ <20
☐ 20-50 (able to count in less than a minute)
☐ 51-499 (typically an average case of varicella has 200-400 lesions)
☐ >500 (lesions confluent in some places, can't see normal skin between)

On any one part of the body (e.g., face or arm), are all the lesions in the same state of development? ☐ Yes ☐ No ☐ Unknown

How big are most of the lesions? *(Do not measure superinfected lesions.)*
☐ Small (1-5 mm)
☐ Large (5-10 mm)
☐ Neither *(describe)* ______

Have any lesions crusted? ☐ Yes ☐ No ☐ Unknown
If *Yes*, how many days did it take for the first lesions to crust? ______

How itchy is the rash? ☐ Not at all ☐ Somewhat ☐ Very ☐ Unknown

Does the patient have lymphadenopathy? ☐ Yes ☐ No ☐ Unknown
If *Yes*, describe: ______

Is the patient toxic or moribund now? ☐ Yes ☐ No ☐ Unknown
If *Yes*, describe: ______

*Continues*

## CLINICAL NOTES

## SOURCE / EXPOSURE INFORMATION

Is chickenpox (varicella) occurring in the community? ☐ Yes ☐ No ☐ Unknown

Has the patient had contact with a person with chickenpox or shingles 10-21 days before rash onset? ☐ Yes ☐ No ☐ Unknown

If *Yes*, give date(s) and type of contact: ______

**In the 3 weeks before onset of illness:** *(applies to remainder of section)*

Has the patient been in contact with a person with any other rash illness? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please specify, with date: ______

Has the patient traveled? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please provide locations and dates of travel:

Place: ______ Dates: ______

Place: ______ Dates: ______

Has the patient had contact with mice? ☐ Yes ☐ No ☐ Unknown

Has the patient been camping, hiking, or exposed to woods before onset of illness? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please provide details and dates:

______ Dates: ______

______ Dates: ______

Has the patient received insect bites? ☐ Yes ☐ No ☐ Unknown

Has the patient been exposed to ticks? ☐ Yes ☐ No ☐ Unknown

## VACCINATION HISTORY

Has the patient received chickenpox (varicella) vaccine? ☐ Yes ☐ No ☐ Unknown

*(Chickenpox vaccine was licensed in the United States in 1995.)*

If *Yes*, dose #1 date ___/___/___ or age ______

dose #2 date ___/___/___ or age ______

*(only persons >13 years receive a second dose)*

Has the patient ever received smallpox vaccine? ☐ Yes ☐ No ☐ Unknown

*(The smallpox vaccine was routinely given in the U.S. until 1972, was recommended for health care providers until 1976, was administered in the military until 1990.)*

If *Yes*, when was the most recent vaccination? ___/___/___

or at what age? ______

## MEDICAL HISTORY

Has the patient ever had chickenpox or shingles? ☐ Yes ☐ No ☐ Unknown

If *Yes*, when? ___/___/___ or at what age? ______

Is the patient immunocompromised? ☐ Yes ☐ No ☐ Unknown

If *Yes*, specify type of illness *(e.g., cancer, HIV/AIDS)* ______

Does the patient have any other serious underlying medical illnesses? *(e.g., asthma)* ☐ Yes ☐ No ☐ Unknown

If *Yes*, please list: ______

Is the patient sexually active? ☐ Yes ☐ No ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

## DIFFERENTIAL DIAGNOSIS

## MEDICATIONS

Is the patient on medications that suppress the immune system? *(e.g., steroids, chemotherapy, radiation)* ☐ Yes ☐ No ☐ Unknown

If *Yes*, name of medication: ______

Dosage: ______

Method of administration: ______

Is the patient taking antiviral medications? ☐ Yes ☐ No ☐ Unknown

If *Yes*, name of medication: ______

Dosage: ______

Method of administration: ______

Please list all prescription and non-prescription medications that the patient has taken in the past three weeks. *(List drug, dosage, route, dates)*

Is there a history of illicit drug use? ☐ Yes ☐ No ☐ Unknown

If *Yes*, please specify drug, amount (if known), route, and dates:

## LABORATORY

***Other lab testing — Please complete last page***

Have you tested the patient for chickenpox? ☐ Yes ☐ No ☐ Unknown

If *Yes*, what type of test? ______

Results of tests: ______

Date: ___/___/___

Other comments:

## DISPOSITION

**Risk of smallpox**
*using CDC criteria (available at www.cdc.gov/nip/smallpox):*

☐ **Low** ☐ **Moderate** ☐ **High*** ☐ **Unknown**

**If checked, see contact checklist below in Immediate Response Information*

## IMMEDIATE RESPONSE INFORMATION

☐ Institute airborne and contact precautions
☐ Alert infection control
☐ Take digital photographs of rash
☐ Consult ID and/or dermatology

## IF THE PATIENT IS AT HIGH RISK:

☐ Contact local health department

Name: ______ Phone: ______
E-mail: ______ Phone: ______

☐ Contact state epidemiologist

Name: ______ Phone: ______
E-mail: ______ Phone: ______

☐ Contact state BT coordinator

Name: ______ Phone: ______
E-mail: ______ Phone: ______

☐ Contact CDC BT coordinator

Name: ______ Phone: ______
E-mail: ______ Phone: ______

## 24-HOUR FOLLOW-UP INFORMATION

Date of follow -up: ___/___/___
Person making follow-up: ______
Condition of patient: ______
Risk of smallpox 24 hours later: ☐ Low ☐ Moderate ☐ High ☐ Unkn
Action taken: ______

Diagnosis: ______
Was diagnosis confirmed? ☐ Yes ☐ No ☐ Unknown
How was diagnosis confirmed? ______

## 48-HOUR FOLLOW-UP INFORMATION

Date of follow -up: ___/___/___
Person making follow-up: ______
Condition of patient: ______
Risk of smallpox 48 hours later: ☐ Low ☐ Moderate ☐ High ☐ Unkn
Action taken: ______

Diagnosis: ______
Was diagnosis confirmed? ☐ Yes ☐ No ☐ Unknown
How was diagnosis confirmed? ______

## 72-HOUR FOLLOW-UP INFORMATION

Date of follow -up: ___/___/___
Person making follow-up: ______
Condition of patient: ______
Risk of smallpox 72 hours later: ☐ Low ☐ Moderate ☐ High ☐ Unkn
Action taken:

Diagnosis: ______
Was diagnosis confirmed? ☐ Yes ☐ No ☐ Unknown
How was diagnosis confirmed? ______

**www.cdc.gov/smallpox**

## CLINICAL NOTES

**PLEASE LIST ALL LABORATORY TESTS ORDERED OR PERFORMED REGARDING THIS ILLNESS**

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________

Date: ______/______/______ Results: ____________________
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☐ Other ____________________

Date: ______/______/______ Results: ____________________
Disease: ____________________
Test: ____________________
Laboratory: ☐ State
☐ Other ____________________