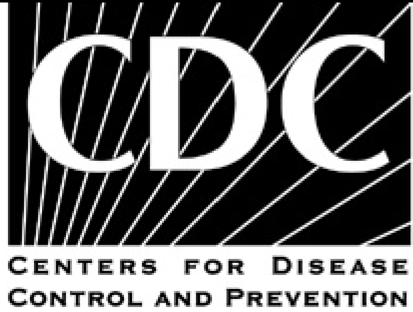


# HUMAN CASES
## INTERIM FIELD SPECIMEN COLLECTION FORM
## ACCESSIONING FORM

CDC/NCID/POXVIRUS SECTION
1600 CLIFTON ROAD MS G-18
ATLANTA, GA 30333

TEL: (404) 639-4931 FAX: (404) 639-3111

*NI = No information available* *State or Local ID#* ____________ *CDC Pox unique ID#* __________

| *CASE NUMBER (Poxvirus Lab use only)* | *DATE RECEIVED* |
|---|---|
| | ________/_______/__________ |

Consultation with the state epidemiologist (www.cste.org/members/state_and_territorial_epi.asp) and state health laboratory (www.aphl.org/public_health_labs/index.cfm) is necessary for submission instructions before sending specimens to CDC.

| *PATIENT INFORMATION* | *PROVIDER INFORMATION (SUBMITTED BY)* |
|---|---|
| ☐ CLINICAL ☐ ENVIRONMENTAL | LAST NAME:_____________________________ |
| Last Name:____________________________ | FIRST NAME:____________________________ |
| First Name:____________________________ | ADDRESS:_______________________________ |
| | ______________________________________ |
| CITY:_________________________________ | CITY:__________________________________ |
| STATE:________________________________ | STATE:_________________________________ |
| COUNTY:_______________________________ | COUNTY:________________________________ |
| ZIP CODE:_____________________________ | ZIP CODE:______________________________ |
| COUNTRY:______________________________ | COUNTRY:_______________________________ |
| SPECIES (If other than human):_______________ | TELEPHONE:_(_____)______________________ |
| SEX: M / F / NI DOB:____/____/_____ NI | TEL 2:__(____)__________________________ |
| HOSPITAL PATIENT NUMBER: ____________ | FAX: _(______)__________________________ |
| | EMAIL:_________________________________ |
| | *DATE CASE IDENTIFIED:* ______/____/_____ |

## *CLINICAL HISTORY*

PATIENT HOSPITALIZED? Y / N / NI
OUTCOME? RECOVERED DIED DATE OF DEATH:______/____/______ NI
FEVER: Y / N / NI FEVER ONSET DATE:______/____/______
RASH: Y / N / NI RASH ONSET DATE: ______/____/______

LESION TYPE: ______MACULES APPROX NUMBER:________LOCATION:________________
______PAPULES APPROX NUMBER:________LOCATION:________________
______VESICLES APPROX NUMBER:________LOCATION:________________
______PUSTULES APPROX NUMBER:________LOCATION:_________________

## *VACCINE HISTORY*

HAS THE PATIENT EVER HAD SMALLPOX? Y / N /
HAS THE PATIENT EVER RECEIVED THE VACCINIA (SMALLPOX) VACCINE? Y / N /
VACCINATION DATE 1:_________________________VACCINATION DATE 2:__________________________
DOES THE PATIENT HAVE A VACCINATION SCAR? Y / N /
HAS THE PATIENT EVER HAD CHICKENPOX? Y / N /
HAS THE PATIENT RECEIVED THE VARICELLA VACCINE? Y / N /
VACCINATION DATE 1:_________________________VACCINATION DATE 2:__________________________
WAS THE PATIENT RECENTLY EXPOSED TO SMALLPOX? Y / N / NI # OF DAYS AGO:_______
CHICKENPOX? Y / N / NI # OF DAYS AGO:_______
DID THE PATIENT TAKE STEROIDS OR IMMUNOSUPPRESSANT DRUGS DURING THE MONTH PRIOR TO THE RASH ONSET? Y / N / NI

## *ADDITIONAL CLINICAL OBSERVATIONS AND BRIEF PATIENT HISTORY*

## *DIAGNOSTIC NOTES*

*CLINICAL DIAGNOSIS*

______ORTHOPOX
______VACCINIA
______MONKEYPOX
______VARIOLA
______VARICELLA
______VARICELLA ZOSTER
______COWPOX
______OTHER SPECIFY:______________________________________________________

*INVESTIGATOR INFORMATION*
*(Person submitting case history and specimens)*

LAST NAME:______________________________________________________

FIRST NAME:______________________________________________________

TITLE:______________________________________________________

ORGANIZATION:______________________________________________________

ADDRESS:______________________________________________________

CITY:______________________STATE:________________ZIP:__________

TELEPHONE:__(  )______-__________FAX:__(  )_______-____________

EMAIL:______________________________________________________

*SPECIMEN MATERIAL*

DATE COLLECTED:________/________/________

**DASH NUMBER:**

**SAMPLE MATERIAL** | **METHOD** | **ASTRO:**

___MACULE/PAPULE
___VESICLE SKIN ____ SWAB
___VESICLE FLUID ____SLIDE **BRRAT:**
___PUSTULE SKIN ____VACUTAINER
___PUSTULE FLUID ____CONTAINER
___CRUST ____EM GRID
___OROPHARYNGEAL TISSUE ____TOUCHPREP **BT NUMBER:**
___OTHER TISSUE ____BIOPSY/ FORMALIN
___CSF ____BIOPSY/ DRY
___BLOOD
___SERUM
___OTHER
___NO INFORMATION ANATOMICAL SITE:___________________________________

*SPECIMEN MATERIAL*

DATE COLLECTED:________/________/________

**DASH NUMBER:**

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