WHO Global Clinical Platform for Monkeypox
Data for public health response

Global Clinical Data Platform

Monkeypox

CASE REPORT FORM (CRF)

INTRODUCTION

The Rapid Core CRF is designed to collect data obtained through examination, interview and review of hospital or clinic notes of patients with suspected, probable, or confirmed monkeypox infection. Data may be collected prospectively or retrospectively. The data collection period is defined as the period from hospital admission, or first clinic visit to discharge from care, transfer, death, or continued hospitalization without possibility of continued data collection.

This CRF has three modules:

Module 1:	To be completed on the first day of presentation or admission to the health centre (baseline visit).
Module 2:	To be completed daily during hospital stay for as many days as resources allow, or on follow-up visits to health centre.
Module 3:	To be completed at last visit, either hospital discharge, transfer, last outpatient follow-up or death.
Pregnancy module:	To be completed if currently pregnant or recently pregnant <=21 days.

GENERAL GUIDANCE

Participant identification numbers consist of a site code and a participant number. You can register on the data management system by completing MPX Registration Form, and our data management team will contact you with instructions for data entry and will assign you a 5-digit site code at that time.
Please contact us at monkeypox_clinicaldataplatform@who.int for any further information.

MODULE 1. Complete on hospital admission (within 24 hrs from admission) or first visit to outpatient

Facility/clinic name _____ **Country** _____

Type of encounter: ☐Outpatient ☐Emergency department ☐Inpatient wards ☐Other site, specify_____

Date of enrolment into the clinical data platform [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

1a. DEMOGRAPHICS

Sex at birth ☐Male ☐Female ☐Intersex ☐Not specified

Date of birth [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

If date of birth is Unknown, record: **Age** [_][_][_] **years** OR [_][_] **months** OR [_][_] **days**

Health care worker? ☐Yes ☐No ☐Unknown **Laboratory worker?** ☐Yes ☐No ☐Unknown

If yes: ☐not wearing all recommended PPE ☐wearing all recommended PPE ☐other specify

Race/ethnicity (tick all that apply) ☐Asian ☐African/Black ☐Caucasian/White ☐Hispanic/Latino ☐another race or ethnicity ☐Unknown

Pregnant?* ☐Yes ☐No ☐Unknown ☐N/A **If yes: Gestational weeks assessment** [___][_] weeks

If No, was person recently pregnant: within ≤ 21 days of symptom onset? ☐Yes ☐No ☐Unknown.

If Yes, also complete Pregnancy Module

If No, was she pregnant within 22-42 days from admission? ☐Yes ☐No ☐Unknown

History of tetanus vaccination ☐Yes ☐No ☐Unknown

1b. Exposure and social history

Any known link to probable or confirmed case of MPX with ≤ 21 days prior to symptom onset?

☐Yes ☐No ☐Unknown

*If yes: nature of contact: _____

Sexually active within ≤ 21 days prior to symptom onset: ☐Yes ☐No ☐Unknown

If yes: select sex of sexual partner(s): ☐ Female ☐Male ☐Intersex ☐Unknown

International travel within ≤ 21 days prior to symptom onset? ☐Yes ☐No ☐Unknown

If yes: list countries visited

_____

Contact with possible animal source within ≤ 21 days prior to symptom onset? ☐Yes ☐No ☐Unknown

If yes: describe_____

_____

_____

1c. DATE OF ONSET AND VITAL SIGNS *(baseline visit)*

Symptom onset (date of first/earliest symptom) [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

First described symptom/s:

Sore throat	☐Yes	☐No ☐Unknown	Proctitis	☐Yes	☐No ☐Unknown
Muscle aches (myalgia)	☐Yes	☐No ☐Unknown	Pain with swallowing	☐Yes	☐No ☐Unknown
Headache	☐Yes	☐No ☐Unknown	Difficulty swallowing	☐Yes	☐No ☐Unknown
Ocular symptoms (pain, redness, visual loss)	☐Yes	☐No ☐Unknown	Pain with urination	☐Yes	☐No ☐Unknown
Fatigue/malaise	☐Yes	☐No ☐Unknown	Urethritis	☐Yes	☐No ☐Unknown
Oral pain	☐Yes	☐No ☐Unknown	Chest pain	☐Yes	☐No ☐Unknown
Nausea	☐Yes	☐No ☐Unknown	Decreased urine output	☐Yes	☐No ☐Unknown
Vomiting	☐Yes	☐No ☐Unknown	Dizziness	☐Yes	☐No ☐Unknown
Diarrhoea	☐Yes	☐No ☐Unknown	Joint pain (arthralgia)	☐Yes	☐No ☐Unknown
Rectal pain	☐Yes	☐No ☐Unknown	Psychologic disturbance	☐Yes	☐No ☐Unknown
Lesions	☐Yes	☐No ☐Unknown	Other _____	☐Yes	☐No ☐Unknown

Lymphadenopathy: ☐Yes ☐No ☐Unknown

If yes,

Axillary	☐Present	☐Present and tender
Cervical	☐Present	☐Present and tender
Inguinal	☐Present	☐Present and tender
Other	☐Present	☐Present and tender

Specify other: _____

Admission date or visit date at this facility:
[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Temperature [_][___].[_] ☐°C ☐°F **Heart rate** [___][___][_]beats/min

Respiratory rate [_][___]breaths/min **BP** [_] [_] [_](systolic) [___][_][_](diastolic) mmHg

Severe dehydration ☐Yes ☐No ☐Unknown

Alert **Voice** **Pain** **Unresponsive** (circle one)

Height [___] [___][___]cm **Weight** [_][_][___]kg

1d. CO-MORBIDITIES *(existing at baseline visit)*								
Chronic cardiac disease (not hypertension)	☐Yes	☐No	☐Unknown	Diabetes	☐Yes	☐No	☐Unknown
Hypertension	☐Yes	☐No	☐Unknown	Current smoking	☐Yes	☐No	☐Unknown
Chronic pulmonary disease	☐Yes	☐No	☐Unknown	Tuberculosis (*active*)	☐Yes	☐No	☐Unknown
Asthma	☐Yes	☐No	☐Unknown	Tuberculosis (*previous*)	☐Yes	☐No	☐Unknown
Chronic kidney disease	☐Yes	☐No	☐Unknown	Asplenia	☐Yes	☐No	☐Unknown
Chronic liver disease	☐Yes	☐No	☐Unknown	Malignant neoplasm	☐Yes	☐No	☐Unknown
Chronic neurological disorder	☐Yes	☐No	☐Unknown	If yes, on therapy for neoplasm at present?	☐Yes	☐No	☐Unknown
Current alcohol use disorder	☐Yes	☐No	☐Unknown	On immunosuppressants	☐Yes	☐No	☐Unknown
Known current sexually transmitted infection?	☐Yes	☐No	☐Unknown	If yes, specify _____			
If yes, specify: ☐ N.gonorrhoeae ☐Syphilis ☐HSV ☐Chlamydia trachomatis ☐Other _____				Immunosuppressive condition ☐Yes ☐No ☐Unknown If yes, specify: _____			

HIV ☐Yes (on ART) ☐Yes (not on ART) ☐Yes (ART status unknown) ☐No ☐Unknown

ART regimen_____

Most recent CD4: [__][__][__][__] Viral load: _____ copies/ml

1e. Rash evaluation (baseline visit)

Number of lesions on the entire body that are NOT resolved (resolved = scabbed and desquamated and fresh layer of skin has formed underneath):

☐0 ☐ 1–5 ☐ 6–25 ☐ 26–100 ☐ 101-250 ☐ > 250

Number of lesions on the right leg (to the hip crease, including front and back of foot and leg): [__][__][__][__]
Number of lesions on the right arm (including hand and shoulder): [__][__][__][__]
Number of lesions on the left leg (to the hip crease, including front and back of foot and leg): [__][__][__][__]
Number of lesions on the left arm (including hand and shoulder): [__][__][__][__]
Number of lesions on the genitals (from hip crease to hip crease): [__][__][__][__]
Number of lesions in the oral mucosa [__][__][__][__]
Number of lesions in the perianal area [__][__][__][__]

Does the patient have active lesions in the following areas:

Face	☐Yes	☐No	☐Unknown	Palms of hands	☐Yes	☐No	☐Unknown
Nares	☐Yes	☐No	☐Unknown	Arms	☐Yes	☐No	☐Unknown
Mouth	☐Yes	☐No	☐Unknown	Forearms	☐Yes	☐No	☐Unknown
Chest	☐Yes	☐No	☐Unknown	Thighs	☐Yes	☐No	☐Unknown
Abdomen	☐Yes	☐No	☐Unknown	Legs	☐Yes	☐No	☐Unknown
Back	☐Yes	☐No	☐Unknown	Soles of feet	☐Yes	☐No	☐Unknown
Perianal	☐Yes	☐No	☐Unknown	Other	☐Yes	☐No	☐Unknown
Genitals	☐Yes	☐No	☐Unknown	Specify where:			

Types of lesions on the body:

Macule	☐Yes	☐No	☐Unknown	Umbilicated pustule	☐Yes	☐No	☐Unknown
Papule	☐Yes	☐No	☐Unknown	Ulcerated lesion	☐Yes	☐No	☐Unknown
Early vesicle	☐Yes	☐No	☐Unknown	Crusting of a mature lesion	☐Yes	☐No	☐Unknown
Small pustule	☐Yes	☐No	☐Unknown	Partially removed scab	☐Yes	☐No	☐Unknown

Pain at any lesion site: ☐Yes ☐No If yes, pain score (0–10: 0 is no pain; 10 is worst imaginable pain: [___] [___]

1f. SIGNS AND SYMPTOMS (first encounter)					
Sore throat	☐Yes	☐No ☐Unknown	Proctitis	☐Yes	☐No ☐Unknown
Muscle aches (myalgia)	☐Yes	☐No ☐Unknown	Pain with swallowing	☐Yes	☐No ☐Unknown
Headache	☐Yes	☐No ☐Unknown	Difficulty swallowing	☐Yes	☐No ☐Unknown
Ocular symptoms (pain, redness, visual loss)	☐Yes	☐No ☐Unknown	Pain with urination	☐Yes	☐No ☐Unknown
Fatigue/malaise	☐Yes	☐No ☐Unknown	Urethritis	☐Yes	☐No ☐Unknown
Oral Pain	☐Yes	☐No ☐Unknown	Chest pain	☐Yes	☐No ☐Unknown
Nausea	☐Yes	☐No ☐Unknown	Decreased urine output	☐Yes	☐No ☐Unknown
Vomiting	☐Yes	☐No ☐Unknown	Dizziness	☐Yes	☐No ☐Unknown
Diarrhoea	☐Yes	☐No ☐Unknown	Joint pain (arthralgia)	☐Yes	☐No ☐Unknown
Rectal pain	☐Yes	☐No ☐Unknown	Psychologic disturbance	☐Yes	☐No ☐Unknown

Lymphadenopathy: ☐Yes ☐No ☐Unknown
If yes,
Axillary ☐Present ☐Present and tender
Cervical ☐Present ☐Present and tender
Inguinal ☐Present ☐Present and tender
Other ☐Present ☐Present and tender
Specify other: _____

1g. LABORATORY INVESTIGATIONS on admission for hospitalized patients or baseline visit (for outpatient laboratory investigations performed at clinical discretion)

Investigation	Values		Investigation	Values	
ALT (U/L)		☐ Not Done	Glucose (mg/dL)		☐ Not Done
AST (U/L)		☐ Not Done	Lactate (mmol/L)		☐ Not Done
Creatinine (µmol/L)		☐ Not Done	Haemoglobin (g/L)		☐ Not Done
Potassium (mEg/L)		☐ Not Done	Total bilirubin (mg/dL)		☐ Not Done
Urea (mmol/L)		☐ Not Done	WBC count (cells x 10^9/L)		☐ Not Done
Creatinine kinase (U/L)		☐ Not Done	Platelets (x10^9/L)		☐ Not Done
Calcium (mg/dL)		☐ Not Done	Prothrombin time (secs)		☐ Not Done
Sodium (mEq/L)		☐ Not Done	Activated partial thromboplastin time (aPTT)		☐ Not Done
CRP (mg/dL)		☐ Not Done	Other specify		

1h. History of smallpox or monkeypox vaccination

History of smallpox vaccination before 1980? ☐Yes ☐No ☐Unknown

Source of information: ☐Documented evidence (vaccine card/vaccine passport/facility-based record/other)

☐Visible scar ☐Recall

History of smallpox or monkeypox vaccination in past year ☐Yes ☐No ☐Unknown

If yes, number of doses received: ☐1 ☐ 2 ☐3 ☐Unknown

Source of information: ☐Documented evidence (vaccine card/vaccine passport/facility-based record/other) ☐Recall

Dose 1, Date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]specify ☐Jynneos ☐IMVANEX ☐ Imvamune

☐ ACAM2000 ☐APSV: Aventis Pasteur smallpox vaccine ☐LC16m8 ☐other _____

Dose 2, Date [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]specify ☐Jynneos ☐IMVANEX ☐ Imvamune

☐ ACAM2000 ☐APSV: Aventis Pasteur smallpox vaccine ☐LC16m8 ☐other _____

Dose 3, Date [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]specify ☐Jynneos ☐IMVANEX ☐ Imvamune

☐ ACAM2000 ☐APSV: Aventis Pasteur smallpox vaccine ☐LC16m8 ☐other _____

MODULE 2. Follow up during hospital stay or on follow-up visits – daily or every 3-5 days

Date of follow up [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Type of encounter: ☐outpatient ☐emergency department ☐inpatient wards ☐Other site, specify_____

2a. LESION ASSESSMENT (daily):

Have any new lesions appeared in the last 24 hours? ☐ Yes ☐ No

Number of lesions on the entire body that are NOT resolved (resolved = scabbed and desquamated):

☐ **0** ☐ **1–5** ☐ **6–25** ☐ **26–100** ☐ **101-250** ☐ **>250**

Number of lesions on the right leg (to the hip crease, including front and back of foot and leg): [__][__][__][__]
Number of lesions on the right arm (including hand and shoulder): [__][__][__][__]
Number of lesions on the left leg (to the hip crease, including front and back of foot and leg): [__][__][__][__]
Number of lesions on the left arm (including hand and shoulder): [__][__][__][__]
Number of lesions on the genitals (from hip crease to hip crease): [__][__][__][__]
Number of lesions in the oral mucosa [__][__][__][__]
Number of lesions in the perianal area [__][__][__][__]

Does the patient have active lesions in the following areas:

Face	☐Yes ☐No ☐Unknown	Palms of hands	☐Yes ☐No ☐Unknown
Nares	☐Yes ☐No ☐Unknown	Arms	☐Yes ☐No ☐Unknown
Mouth	☐Yes ☐No ☐Unknown	Forearms	☐Yes ☐No ☐Unknown
Chest	☐Yes ☐No ☐Unknown	Thighs	☐Yes ☐No ☐Unknown
Abdomen	☐Yes ☐No ☐Unknown	Legs	☐Yes ☐No ☐Unknown
Back	☐Yes ☐No ☐Unknown	Soles of feet	☐Yes ☐No ☐Unknown
Perianal	☐Yes ☐No ☐Unknown	Other	☐Yes ☐No ☐Unknown
Genitals	☐Yes ☐No ☐Unknown	Specify where:	

Types of lesions on the body:

Macule	☐Yes ☐No ☐Unknown	Umbilicated pustule	☐Yes ☐No ☐Unknown
Papule	☐Yes ☐No ☐Unknown	Ulcerated lesion	☐Yes ☐No ☐Unknown
Early vesicle	☐Yes ☐No ☐Unknown	Crusting of a mature lesion	☐Yes ☐No ☐Unknown
Small pustule	☐Yes ☐No ☐Unknown	Partially removed scab	☐Yes ☐No ☐Unknown

Pain at any lesion site: ☐YES ☐NO
If yes, pain score (0–10: 0 is no pain; 10 is worst imaginable pain: [___][___]

2b. VITAL SIGNS *(record most abnormal value between 00:00 to 24:00) or any value at visit*

Temperature [_][___].[_]°C °F **Heart rate** [___][___][_]beats/min **Respiratory rate** [_][___]breaths/min

BP [_] [_] [_](systolic) [___][_][_](diastolic) mmHg **Alert** **Voice** **Pain** **Unresponsive** (circle one)

MODULE 3. Complete at discharge/death/last follow up

3a. DIAGNOSTIC/PATHOGEN TESTING Please list all diagnostic tests for pathogens (if multiple tests performed on same day, list all results on a separate line, add extra 3a form)			
Date	**Specimen type**	**Test performed**	**Result**
_D_ _D_ /_M_ _M_ /202 _Y_	ONasal/NP swab OThroat swab OCombined nasal/NP + throat swab OSputum OBAL OETA OLesion/crust swab OUrine OStool/rectal swab OBlood OOther, specify: ___________	OMonkeypox PCR OOrthopoxvirus PCR OMonkeypox viral culture OSequence/genotyping OBacterial culture Other___________	OPositive, result: ___________ ONegative OUnknown
_D_ _D_ /_M_ _M_ /202 _Y_	ONasal/NP swab OThroat swab OCombined nasal/NP + throat swab OSputum OBAL OETA OLesion/crust swab OUrine OStool/rectal swab OBlood OOther, specify: ___________	OMonkeypox PCR OOrthopoxvirus PCR OMonkeypox viral culture OSequence/genotyping OBacterial culture Other___________	OPositive, result: ___________ ONegative OUnknown
_D_ _D_ /_M_ _M_ /202 _Y_	ONasal/NP swab OThroat swab OCombined nasal/NP + throat swab OSputum OBAL OETA OLesion/crust swab OUrine OStool/rectal swab OBlood OOther, specify: ___________	OMonkeypox PCR OOrthopoxvirus PCR OMonkeypox viral culture OSequence/genotyping OBacterial culture Other___________	OPositive, result: ___________ ONegative OUnknown
_D_ _D_ /_M_ _M_ /202 _Y_	ONasal/NP swab OThroat swab OCombined nasal/NP + throat swab OSputum OBAL OETA OLesion/crust swab OUrine OStool/rectal swab OBlood OOther, specify: ___________	OMonkeypox PCR OOrthopoxvirus PCR OMonkeypox viral culture OSequence/genotyping OBacterial culture Other___________	OPositive, result: ___________ ONegative OUnknown
_D_ _D_ /_M_ _M_ /202 _Y_	ONasal/NP swab OThroat swab OCombined nasal/NP + throat swab OSputum OBAL OETA OLesion/crust swab OUrine OStool/rectal swab OBlood OOther, specify: ___________	OMonkeypox PCR OOrthopoxvirus PCR OMonkeypox viral culture OSequence/genotyping OBacterial culture Other___________	OPositive, result: ___________ ONegative OUnknown
_D_ _D_ /_M_ _M_ /202 _Y_	ONasal/NP swab OThroat swab OCombined nasal/NP + throat swab OSputum OBAL OETA OLesion/crust swab OUrine OStool/rectal swab OBlood OOther, specify: ___________	OMonkeypox PCR OOrthopoxvirus PCR OMonkeypox viral culture OSequence/genotyping OBacterial culture Other___________	OPositive, result: ___________ ONegative OUnknown

3b. COMPLICATIONS At any time, did the patient experience:								
Shock	☐Yes	☐No	☐Unknown	Bacteraemia	☐Yes	☐No	☐Unknown
Seizure	☐Yes	☐No	☐Unknown	Bleeding	☐Yes	☐No	☐Unknown
Meningitis/encephalitis	☐Yes	☐No	☐Unknown	Stroke: ischaemic stroke	☐Yes	☐No	☐Unknown
Anaemia	☐Yes	☐No	☐Unknown	Myocarditis/pericarditis/	☐Yes	☐No	☐Unknown
Cardiac arrhythmia	☐Yes	☐No	☐Unknown	Acute renal injury	☐Yes	☐No	☐Unknown
Cardiac arrest	☐Yes	☐No	☐Unknown	Pancreatitis	☐Yes	☐No	☐Unknown
Pneumonia	☐Yes	☐No	☐Unknown	Liver dysfunction	☐Yes	☐No	☐Unknown
Cellulitis	☐Yes	☐No	☐Unknown	Cardiomyopathy	☐Yes	☐No	☐Unknown
Acute respiratory distress syndrome (ARDS)	☐Yes	☐No	☐Unknown	Urinary retention If yes, specify	☐Yes	☐No	☐Unknown
Necrotizing infection	☐Yes	☐No	☐Unknown	Ocular infection	☐Yes	☐No	☐Unknown
Abscess	☐Yes	☐No	☐Unknown	Other: _____	☐Yes	☐No	☐Unknown

3c. LABORATORY INVESTIGATIONS (if done during a visit or hospital admission, record the most abnormal value)					
Investigation	**Values**		**Investigation**	**Values**	
ALT (U/L)		☐ Not Done	Glucose (mg/dL)		☐ Not Done
AST (U/L)		☐ Not Done	Lactate (mmol/L)		☐ Not Done
Creatinine (µmol/L)		☐ Not Done	Haemoglobin (g/L)		☐ Not Done
Potassium (mEg/L)		☐ Not Done	Total bilirubin (mg/dL)		☐ Not Done
Urea (mmol/L)		☐ Not Done	WBC count (cells x 10^9/L)		☐ Not Done
Creatinine kinase (U/L)		☐ Not Done	Platelets (x10^9/L)		☐ Not Done
Calcium (mg/dL)		☐ Not Done	Prothrombin time (secs)		☐ Not Done
Sodium (mEq/L)		☐ Not Done	Activated partial thromboplastin time (aPTT)		☐ Not Done
CRP (mg/dL)		☐ Not Done	Other specify		

3d. MEDICATIONS at any time, were any of the following administered:

Oral/orogastric fluids? ☐Yes ☐No ☐Unknown **Intravenous fluids?** ☐Yes ☐No ☐Unknown

Experimental orthopox antiviral? ☐Yes ☐No ☐Unknown

☐**Tecovirimat:** First date given: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Dose: _____ Frequency: _____ Route:_____ Duration: _____ in days _____

☐**Brincidofovir:** First date given: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Dose: _____ Frequency: _____ Route: _____ Duration: _____ in days _____

☐**Cidofovir:** First date given: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Dose: _____ Frequency: _____Route: _____ Duration: _____ in days _____

Other experimental agent**:** First date given: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Dose: _____ Frequency: _____Route: _____ Duration: _____ in days _____

If yes, specify: _____

Antibacterial: ☐ Yes ☐ No ☐Unknown. If yes, specify:	First date given:	Frequency	Route	Duration in ___ days
Amoxicillin-clavulanic	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		☐PO ☐IV	
Ceftriaxone	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		☐PO ☐IV ☐IM	
Doxycycline	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		☐PO ☐IV	
Other : _____	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		☐PO ☐IV ☐IM	
Other : _____	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		☐PO ☐IV ☐IM	
Antifungal: ☐ Yes ☐ No ☐Unknown. If yes, specify:	First date given:	Frequency	Route	Duration in ___ days
Fluconazole	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		☐PO ☐IV	
Other : _____	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		☐PO ☐IV ☐IM	

3e. SUPPORTIVE CARE For those hospitalized, at any time during hospitalization, did the patient receive/undergo:

ICU or high dependency unit admission? ☐Yes ☐No ☐Unknown **If yes,** total duration:_____days
Date of ICU admission [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A
Date of ICU discharge [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐In ICU at outcome ☐N/A

Oxygen therapy? ☐Yes ☐No ☐Unknown **If yes,** complete all: Total duration: _____days

Oxygen flow: ☐1–5 L/min ☐6–10 L/min ☐11–15 L/min ☐ > 15 L/min

Interface: ☐Nasal prongs ☐HF nasal cannula ☐Mask ☐Mask with reservoir ☐CPAP/NIV mask

Non-invasive ventilation? (e.g. BiPAP, CPAP) ☐Yes ☐No ☐Unknown **If yes,** total duration: _____days

Invasive ventilation (any)? ☐Yes ☐No ☐Unknown **If yes,** total duration: _____days

Extracorporeal (ECMO) support? ☐Yes ☐No ☐Unknown **If yes,** total duration: _____days

Inotropes/vasopressors? ☐Yes ☐No ☐Unknown **If yes,** total duration: _____days

Renal replacement therapy (RRT) or dialysis? ☐Yes ☐No ☐Unknown

3f. OUTCOME

Outcome date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐Unknown

Ever hospitalized? If yes, length of hospitalization ____ days

Outcome: choose one ☐Discharged from care alive ☐Hospitalized ☐Transfer to other facility ☐Death ☐ Discharged to palliative care ☐Unknown

If discharged alive:

Is patient able to self-care at discharge versus before illness: ☐Same as before illness ☐Worse ☐Better ☐Unknown

Are lesions resolved? ☐Yes ☐No ☐Unknown.

If yes, what was date of resolution [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_], ☐ unknown

If no, what is the <u>number of lesions on the entire body that are NOT resolved (resolved = scabbed and desquamated with fresh layer of skin)</u>:

☐ 0 ☐ 1–5 ☐ 6–25 ☐ 26–100 ☐ >100

Residual symptoms, list: _____
_____
_____
_____
_____

3g. CLINICAL INCLUSION CRITERIA Final

Suspected ☐Yes ☐No

Probable ☐Yes ☐No

Confirmed ☐Yes ☐No

**See definitions here:*
https://www.who.int/publications/i/item/WHO-MPX-Surveillance-2022.2

ADDENDUM – PREGNANCY MODULE

To be completed for women who are either:

- **currently pregnant, or**
- **recently pregnant (within 21 days of pregnancy outcome)**

Complete within 24 hrs from hospital admission or outpatient facility

P-1a. PREGNANCY STATUS UPON ADMISSION	
Pregnant not in labour	☐
Pregnant in labour	☐
Postpartum [days]	☐ [days] Breastfeeding? ☐Yes ☐No
Post-abortion/miscarriage	☐
Number of fetuses	☐Singleton ☐Twin ☐Triplet ☐Other [number] ☐Unknown
Was this an IVF pregnancy?	☐Yes ☐No ☐Unknown

P-1b. ABORTION OR MISCARRIAGE *(prior to admission)*	
Date of induced abortion or spontaneous abortion/missed abortion/miscarriage?	
[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	
Were symptoms of MPX present at the time?	☐Yes ☐No ☐Unknown

P-1c. OBSTETRIC HISTORY	
Number of previous pregnancies beyond 22 weeks' gestation	[number]
Number of previous vaginal deliveries	[number]
Number of previous caesarean deliveries	[number]

P-1d. Please tick any which apply to previous deliveries:			
Preterm birth (< 37 weeks 'gestation)	☐Yes	☐No	☐Unknown
Congenital anomaly	☐Yes	☐No	☐Unknown
Stillborn	☐Yes	☐No	☐Unknown
Neonatal death (≤ 7 days)	☐Yes [_Day_]	☐No	☐Unknown
Weight < 2500g	☐		
Weight > 4500g	☐		

P-1e. ALCOHOL, DRUGS – RISK FACTORS DURING THIS PREGNANCY			
Alcohol consumption	☐Yes	☐No	☐Unknown
Illicit/recreational drug use	☐Yes	☐No	☐Unknown
Smoking use	☐Yes	☐No	☐Unknown

P-1f. MEDICATIONS DURING THIS PREGNANCY *(prior to onset of current illness episode)*				
Fever or pain treatment	**Acetaminophen/paracetamol**	☐Yes	☐No	☐Unknown
	NSAIDs	☐Yes	☐No	☐Unknown
	Others (specify):			
Anticonvulsants	☐Yes	☐No	☐Unknown	**If yes, specify generic name:** _____
Anti-nausea	☐Yes	☐No	☐Unknown	**If yes, specify generic name:** _____
Prenatal vitamins and micronutrients	☐Yes	☐No	☐Unknown	**If yes, specify generic name:** _____
Antivirals	☐Yes	☐No	☐Unknown	**If yes, specify generic name:** _____
Antibiotics	☐Yes	☐No	☐Unknown	**If yes, specify generic name:** _____

P-1g. FETAL HEART RATE *(first available data at presentation/admission)*	
Fetal heart rate	**(FHR):** [_ _][_ _][_ _] beats/min

Complete at discharge/death or future delivery

P-2a. DELIVERY, PREGNANCY AND MAXIMAL CHARACTERISTICS	
Delivery during admission	☐Yes ☐No
Delivery date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Mode of delivery	☐ **Vaginal delivery** ☐ **Caesarean section** Reason for c-section: ☐ Prolonged labour ☐ Abnormal positioning ☐ Fetal distress ☐ Birth defects ☐ Repeat caesarean ☐ Chronic health condition ☐ Cord prolapse ☐ Cephalopelvic disproportion (CPD) ☐ Unknown ☐ Genital lesions
Onset of labour	☐ Spontaneous ☐ Caesarean section before labour ☐ Induced ☐ Unknown
Fetal presentation at delivery	☐ Cephalic ☐ Transverse ☐ Breech
Amniotic fluid at delivery	☐ Clear ☐ Meconium stained ☐ Unknown

P-2b. PREGNANCY OUTCOME OTHER THAN LIVE BIRTH AT DISCHARGE	
Pregnancy outcome	☐Undelivered/intact pregnancy ☐Spontaneous abortion* ☐Induced abortion* ☐Missed abortion* ☐Macerated stillbirth* ☐Fresh stillbirth* ☐Post-abortion/postpartum on admission* *Date of pregnancy outcome: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Maternal death	☐Yes ☐No **If yes, what was the underlying cause of death?** ☐Abortive outcome ☐Hypertensive disorders in pregnancy, childbirth, and the puerperium ☐Obstetric haemorrhage ☐Pregnancy-related infection ☐Other obstetric complication not included in above causes ☐Unanticipated complications of management (e.g. anaesthesia-related complications) ☐Indirect maternal death ☐Obstetric death of unspecified cause ☐Deaths from a coincidental cause (e.g. motor vehicle accident)

P-2c. COMPLICATIONS				
Complications during the course of pregnancy	Gestational diabetes	☐Yes	☐No	☐Unknown
	Gestational hypertension	☐Yes	☐No	☐Unknown
	Anaemia (Hb < 11 g/dL)	☐Yes	☐No	☐Unknown
	Obstetric infections	☐Yes	☐No	☐Unknown
	Intrauterine growth restriction	☐Yes	☐No	☐Unknown
	Bleeding	☐Yes	☐No	☐Unknown
	Pre-eclampsia	☐Yes	☐No	☐Unknown
	Eclampsia	☐Yes	☐No	☐Unknown

Acute or late stage pregnancy complications	Placental previa/accreta/percreta	☐Yes	☐No	☐Unknown
	Preeclampsia/eclampsia	☐Yes	☐No	☐Unknown
	Placental abruption	☐Yes	☐No	☐Unknown
	Preterm contractions	☐Yes	☐No	☐Unknown
	Preterm labour	☐Yes	☐No	☐Unknown
	Preterm rupture of membranes	☐Yes	☐No	☐Unknown
	Puerperal septicaemia or severe infection	☐Yes	☐No	☐Unknown
	STI untreated (i.e. herpes, syphilis, chlamydia, gonorrhoea)	☐Yes	☐No	☐Unknown
	Haemorrhage	☐Yes	☐No	☐Unknown
	If haemorrhage, which type: ☐ Antepartum/intrapartum ☐ Postpartum haemorrhage ☐ Abortion-related			
	Embolic disease	☐Yes	☐No	☐Unknown
	Anaesthetic complication	☐Yes	☐No	☐Unknown

P-3d. TREATMENT DURING HOSPITALIZATION or outpatient course did the patient receive/undergo:			
Tocolysis	☐Yes	☐No	☐Unknown
Induction of labour	☐Yes	☐No	☐Unknown

P-3e. SAMPLE COLLECTION for MPX testing				
Any sampling conducted? ☐Yes ☐No ☐Unknown If Yes, describe the test and the results:	☐Amniotic fluid	[_test description__] ☐ PCR ☐ Other [specify]	[_date of collection__] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	[_____result_____] ☐ Positive ☐ Negative ☐ Undetermined
	☐Placenta	[_test description__] ☐ PCR ☐ Other [specify]	[_date of collection__] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	[_____result_____] ☐ Positive ☐ Negative ☐ Undetermined
	☐Cord blood	[_test description__] ☐ PCR ☐ Other [specify]	[_date of collection__] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	[_____result_____] ☐ Positive ☐ Negative ☐ Undetermined
	☐Vaginal swab	[_test description__] ☐ PCR ☐ Other [specify]	[_date of collection__] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	[_____result_____] ☐ Positive ☐ Negative ☐ Undetermined
	☐Faeces/rectal swab	[_test description__] ☐ PCR ☐ Other [specify]	[_date of collection__] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	[_____result_____] ☐ Positive ☐ Negative ☐ Undetermined
	☐Pregnancy tissue in the case of fetal demise/ induced abortion	[_test description__] ☐ PCR ☐ Other [specify]	[_date of collection__] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	[_____result_____] ☐ Positive ☐ Negative ☐ Undetermined
	☐Breastmilk	[_test description__] ☐ PCR ☐ Other [specify]	[_date of collection__] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	[_____result_____] ☐ Positive ☐ Negative ☐ Undetermined

P-3f. NEONATAL OUTCOMES	
Date of birth [DD/MM/YYYY] **Time of birth** [e.g. 14:21]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] [____:____]
Participant ID of the mother:	[___][___][___][___][___]-- [___][___][___][___] – [__Single digit Baby ID_] **Please complete one form per neonate**
MPX lab test of neonate	☐Performed ☐Not performed ☐Unknown If yes: [_sample collected__] [_test description__][_date of collection__] [_____result_____]
Apgar score at 5 minutes	Score: [___] [___]
Birth weight	Grams: [___] [___] [___] [___]
Respiratory distress syndrome	☐Yes ☐No ☐Unknown
Admission to NICU	☐Yes ☐No ☐Unknown

Neonatal outcome	☐Discharged healthy ☐Discharged with complications/sequelae Details: [_____] ☐Clinical referral to specialist ward /other hospital Details: [_____] ☐Death Date of death: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_] ☐Unknown

If neonate died, primary cause of death	☐Preterm/low birth weight	☐Birth asphyxia	☐Infection	☐Birth trauma
	☐Congenital/birth defects	☐Other	☐Unknown	

Any congenital anomalies	☐Neural tube defects	☐Microcephaly
	☐Congenital malformations of ear	☐Congenital heart defects
	☐Congenital malformations of digestive system	☐Orofacial clefts
	☐Congenital malformations of genital organs	☐Abdominal wall defects
	☐Chromosomal abnormalities	☐Talipes equinovarus/clubfoot
	☐Reduction defects of upper and lower limbs	