MONKEYPOX CASE REPORT FORM

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| **SECTION 1: CASE PROTECTED INFORMATION – Local / Provincial / Territorial use only**  **DO NOT FORWARD THIS SECTION TO PHAC** | |
| **Last name:**  **First name:**  **Usual residential address:**  **City:**  **Postal code:** | **Province/Territory:**  **Phone number:**  **Date of birth (*yyyy-mm-dd*):**  **Local case ID:** |

**Instructions for Completion**

* This form is to be used by medical and/or public health professionals for the reporting of probable and confirmed cases to their local or provincial/territorial health authorities via secure methods.
* If you are a member of the public who has concerns about monkeypox, please visit: <https://www.canada.ca/en/public-health/services/diseases/monkeypox.html>
* Please complete as much detail as possible on this form at the time of the initial report.
* Please submit an updated report when there is a change in case classification and/or there is a change in outcome status for the duration of the illness.
* Please note that variables indicated with a red asterisk (**\***) and pink field are being requested by the World Health Organization under the International Health Regulations.

Instructions to local public health authorities

* **Reporting:** Please report cases using normal local/provincial/territorial methods.

Instructions to provincial / territorial public health authorities

* **Reporting of probable and confirmed cases:** Please report cases using the secure methods established between PHAC and provincial and territorial partners.

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| **SECTION 2: ADMINISTRATIVE INFORMATION** | | | | |
| Initial Report  Updated Report | | | | |
| **Reporting Province/Territory\*** | BC  QC  YK  AB  NB  NT  SK  NS  NU  MB  PE  ON  NL | | | |
| **Forward Sortation Area** (First 3 digits of postal code)  **OR**  **Health region** |  | | | |
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| **SECTION 3: CASE INFORMATION** | | | | |
| **P/T case ID \*** |  | **Laboratory ID** (if available, provide the submitting lab ID sent to the National Microbiology Lab) | |  |
| **Investigation date** | (*yyyy-mm-dd*) | | | |
| **Date reported to Public health\*** | (*yyyy-mm-dd*) | | | |
| **Month/Year of birth**  OR\*  **Age** | *(yyyy-mm)* | | | |
|  | years; if under 2 years, indicate in months: months | | | |
| **Sex assigned at birth\*** | Female  Male  Intersex  Prefer not to respond/disclose  Unknown | | | |
| **Gender identity\***  [Sex and gender based on StatCan](https://www.statcan.gc.ca/en/concepts/definitions/gender-sex-variables) | Woman  Man  Non-binary person  If none of the above, then case identifies as:  Prefer not to respond/disclose  Unknown | | | |
| **Race**  *In our society, people are often described by their race or racial background. These are not based in science, but our race may influence the way we are treated by individuals and institutions, and this may affect our health. Which category(ies) best describes you? Select all that apply* | Black (African, African Canadian, Afro-Caribbean descent)  East Asian (Chinese, Japanese, Korean, Taiwanese descent)  Indigenous (First Nations, Inuk/Inuit, Métis, Other, please specify below)  Latin American (Hispanic or Latin American descent)  Middle Eastern (Arab, Persian, West Asian descent (e.g., Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish)  South Asian (South Asian descent, e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan)  Southeast Asian (Southeast Asian descent, e.g. Cambodian, Filipino, Indonesian, Thai, Vietnamese, Laotian, Malaysian)  White (European descent)  Another race category, specify:  Unknown  Declined to answer | | | |
| **Indigenous identity**  Does the case identify as First Nations, Inuk/Inuit and/or Métis?  Select all that apply | Yes, First Nations  Yes, Métis  Yes, Inuk/Inuit  Other Indigenous, specify:  No  Unknown  Declined to answer | | | |
| **Dwelling type** | Private dwelling (single family home)  Private dwelling (apartment)  Student residence  Rooming house/group home  Assisted living facility | | Long term care facility  Retirement residence  Correctional facility  Shelter/homeless  Unknown  Other, specify: | |
| **Is the case a healthcare worker?\*** | Yes  No  Unknown | |  | |
| **If the case is a healthcare worker, what is the healthcare occupation of the case?** | Administrative services  Allied health professional (e.g. respiratory therapist, physiotherapist, social workers)  Dental professional  Emergency medical personnel  Laboratory worker  Nurse | | Pharmacist or pharmacy technician  Physician  Support services (e.g. cleaners, kitchen staff)  Student  Volunteer  Unknown  Other, specify: | |
| **If case is not a healthcare worker or volunteer, indicate case’s occupation** | Animal worker/volunteer (e.g. animal shelter, wildlife rehabilitation, zoo, veterinary clinic), specify:  Border services  Cleaning/custodial services  Correctional facility worker  Farm worker  Flight attendant  Industrial worker (e.g. mining, construction, warehouse, factory)  Law enforcement (e.g. police, RCMP)  Restaurant/bar worker | | Retail worker (e.g. grocery, retail)  Office worker  Retired  Sex worker  School or daycare worker  Works with homeless/under-housed population  Student  Unemployed  Unknown  Other, specify: | |
| **Case classification\*** | Confirmed  Probable  Suspect  Does not meet definition (e.g., if ruled out after testing) | | | |
| **Did the case have a previous laboratory confirmed mpox infection?** | Yes  No  Unknown  If yes, provide the date\* of previous infection (DD/MM/YYYY; if exact day unknown please enter MM/YYYY; if exact month unknown please enter YYYY):  \*Please use earliest date of: symptom onset date, specimen collection date, test result date, and date of notification to public health. | | | |

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| **SECTION 4: CLINICAL CASE PRESENTATION** | | | | |
| **Was the case hospitalized?\*** | Yes  No  Unknown | **If yes:** | | (*yyyy-mm-dd*) |
| Admission date | |  |
| Discharge date | |  |
| **If the case was hospitalized, what was the main reason for hospitalization?\*** | Due to monkeypox illness  Clinically indicated for another reason  Need for isolation  Other, specify:  Unknown | | | |
| **Was the case admitted to an intensive care unit or high dependency unit?\*** | Yes  No  Unknown |  | | |
| **Outcome status at time of reporting\*** | Recovered | Date of recovery | (*yyyy-mm-dd*) | |
| In hospital |  |  | |
| Symptomatic at home |  | | |
| Deceased | **Date of death**\* | (*yyyy-mm-dd*): | |
| Cause of death, if known at time of reporting: | | |
| Unknown |  | | |

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| **Please provide a summary of the signs and symptoms of the illness and dates of onset if known:** | | | | | | | | | | |
| **The case presents/has presented ANY symptoms: \*** | Yes  No  Unknown | | | | | | | | | |
| **Please provide the onset date of the first symptoms:** **\***       ***(yyyy-mm-dd)*** | | | | | | | | | | |
| **Symptom** | **Symptom present** | | | | | | | | **Symptom onset date  *(yyyy-mm-dd)*** | |
|  | **Yes** | | **No** | | | | **Unknown** | |  | | |
| **Fever\*** |  | |  | | | | ☐ | |  | | |
| **Temperature:**        Celsius  Fahrenheit | | | | | | | | | |
| **Headache\*** |  | |  | | | | ☐ | |  | |
| **Myalgia/arthralgia\*** |  | |  | | | | ☐ | |  | |
| **Fatigue/exhaustion\*** |  | |  | | | | ☐ | |  | |
| **Symptom** | **Symptom present** | | | | | | | | **Symptom onset date  *(yyyy-mm-dd)*** | |
|  | **Yes** | | **No** | | | | **Unknown** | |  | |
| **Swollen lymph nodes\*** |  | |  | | | | ☐ | |  | |
| **Specify location of adenopathy (select all that apply)\*:**  Submandibular  Cervical  Inguinal  Axillary  Unknown  Other, specify: | | | | | | | | | |
| **Chills\*** |  | |  | | | | ☐ | |  | |
| **Sore throat\*** |  | |  | | | | ☐ | |  | |
| **Cough\*** |  | |  | | | | ☐ | |  | |
| **Sweating** |  | |  | | | | ☐ | |  | |
| **Back pain** |  | |  | | | | ☐ | |  | |
| **Conjunctivitis\*** |  | |  | | | | ☐ | |  | |
| **Vomiting/nausea\*** |  | |  | | | | ☐ | |  | |
| **Rash/lesions\*:** |  | |  | | | | ☐ | | **\*** | |
| **macular** |  | |  | | | | ☐ | |  | |
| **papular** |  | |  | | | | ☐ | |  | |
| **vesicular** |  | |  | | | | ☐ | |  | |
| **pustular** |  | |  | | | | ☐ | |  | |
| **ulcerous** |  | |  | | | | ☐ | |  | |
| **crusted** |  | |  | | | | ☐ | |  | |
| **Location(s) of the rash/lesions\*:**  Anogenital/perianal  Oral (mouth, lips, oral mucosa including throat)  Face, excluding oral and mucosal surfaces  Limbs (arms. legs) | | | | | | Hands and palms of hand  Soles of feet  Torso  Other, specify: | | | | |
| **Number of lesions:**  One lesion   2-10 lesions   10-50 lesions | | | | 50-100 lesions   >100 lesions  Unknown | | | | | | |
| **Other symptom, specify:** |  | | | | | | | |  | |
| **Other symptom, specify:** |  | | | | | | | |  | |
| **Other symptom, specify:** |  | | | | | | | |  | |
| **Other symptom, specify:** |  | | | | | | | |  | |
| **Other symptom, specify:** |  | | | | | | | |  | |
| **Were any of the following complications reported?** | | | | | | | | | | |
|  | **Yes** | **No** | | | **Unknown** | | | **Declined to Answer** | | **Symptom onset date  *(yyyy-mm-dd)*** | | |
| **Secondary infection** |  |  | | |  | | |  | |  | |
| **Corneal infection** |  |  | | |  | | |  | |  | |
| **Bronchopneumonia** |  |  | | |  | | |  | |  | |
| **Sepsis** |  |  | | |  | | |  | |  | |
| **Encephalitis** |  |  | | |  | | |  | |  | |
| **Ulcerative lesion with delayed healing** |  |  | | |  | | |  | |  | |
| **Myocarditis** |  |  | | |  | | |  | |  | |
| **Other, specify:** |  | | | | | | | |  | | | |

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| **SECTION 5: MEDICAL RISK FACTORS / HISTORY** | | | | | | | |
| **Please provide a summary of vaccination and treatment** | | | | | | | |
|  | **Details** | | | | | | |
| **Smallpox vaccination(s) received on or after May 1st, 2022** | Did the case receive at least one dose of a 3rd generation smallpox vaccine (e.g., Imvamune®, Jynneos®) **on or after May 1st, 2022**?  Yes  No  Unknown  If yes, please provide details for all doses below: | | | | | | |
| **Dose Number**  **(Order by date administered)** | **Vaccine received** | | **Date administered (DD/MM/YYYY) or year administered if date unknown** | **Route of administration** | **Reason for vaccination** | **Country of vaccination** |
| **Dose 1** | ☐ Imvamune (Imvanex, Jynneos)  ☐ Other 3rd generation smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | ☐ subcutaneous  ☐ intradermal  ☐ unknown | ☐ pre-exposure prophylaxis for mpox  ☐ post-exposure prophylaxis for mpox  ☐ routine immunization against smallpox  Details, if applicable (e.g., specify if occupation-related):   ☐ unknown | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 2** | ☐ Imvamune (Imvanex, Jynneos)  ☐ Other 3rd generation smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | ☐ subcutaneous  ☐ intradermal  ☐ unknown | ☐ series completion for smallpox/mpox  ☐ other: | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 3 (if applicable)**  **Note: if more than 3 doses are recorded, please use additional rows in the appendix** | ☐ Imvamune (Imvanex, Jynneos)  ☐ Other 3rd generation smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | ☐ subcutaneous  ☐ intradermal  ☐ unknown | ☐ other: | ☐ Canada  ☐ US  ☐ Other: |
| **Smallpox vaccination(s) received prior to May 1st, 2022** | Did the case previously receive at least one dose of a 1st or 2nd generation smallpox vaccine (such as ACAM2000**) prior to May 1st, 2022**?  Yes  No  Unknown  If yes, please provide details for all doses below: | | | | | | |
| **Dose Number**  **(Order by date administered)** | | **Vaccine received** | | **Date administered (DD/MM/YYYY) or year administered if date unknown** | | **Country of vaccination** |
| **Dose 1** | | ☐ ACAM2000  ☐ Other smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 2** | | ☐ ACAM2000  ☐ Other smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 3 (if applicable)**  **Note: if more than 3 doses are recorded, please use additional rows in the appendix** | | ☐ ACAM2000  ☐ Other smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | | ☐ Canada  ☐ US  ☐ Other: |
| **Antiviral treatment received for monkeypox \*** | Did the case receive antiviral treatment for monkeypox?  Yes (please specify below)  No antiviral treatment  Unknown  If yes, which antiviral treatment was received?  Tecovirimat  Brincidofovir  Cidofovir  The name of antiviral treatment not known  Other, specify: | | | | | | |

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| **Please provide a summary of the relevant medical risk factors and history:** | | |
|  | **Risk factor/history present** | **Details** |
| **Immunocompromised (e.g. by medication, or by disease such as cancer, diabetes, untreated HIV, etc.)\*** | Yes, due to disease  Yes, due to medication  Yes, reason unknown  No  Unknown | **If yes, specify (select all that apply):**  HIV/AIDS (*see next question*)  Diabetes (type 1 or 2)  Lupus  Organ transplants  Stem cell transplants  Cancer  Chemotherapy  Steroids  Other, specify:  Unknown |
| **Does the case have HIV?\*** | Positive, treated  ☐ Positive, untreated  Negative  Unknown | **If HIV status is positive, CD4 counts**:\*    Unknown |
| **Currently pregnant or post-partum\*** | Yes, Pregnancy, trimester is unknown  Yes, Pregnancy, 1st trimester (from week 1 to the end of week 12)  Yes, Pregnancy, 2nd trimester (from week 13 to the end of week 26)  Yes, Pregnancy, 3rd trimester (from week 27 to the end of the pregnancy)  Post-partum (<6 weeks)  No  Unknown  Not applicable | |
| **Was the case diagnosed with a concurrent sexually transmitted or blood borne infection?\*** | Yes  No  Unknown | **If yes, specify (select all that apply):\***  Chancroid (anal/perianal, genital)  Chlamydia (genital, pharyngeal, rectal)  Gonorrhea (genital, pharyngeal, rectal)  Genital warts, HPV (anal, genital)  Genital herpes,HSV (anal/perianal, oral, genital)  Lymphogranuloma venereum (anal/perianal, genital, oral)  Mycoplasma genitalium (genital, pharyngeal, rectal)  Syphilis (any stage)  Trichomoniasis  Other, specify:  Unknown |
| **Other comorbidities not listed above** | Please list: | |

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| **SECTION 6: RISK FACTORS / EXPOSURE HISTORY** | | |
| **Below exposures refer to the period of 21 days prior to onset of symptoms or diagnosis** | | |
| **Has the case had any day trips, travel and/or overnight visits to other locations outside of the province of residence or Canada?\*** | Yes  No  Unknown  Date of departure (*yyyy-mm-dd*):  Date of return (*yyyy-mm-dd*): | |
| If the case travelled within Canada, specify province, territory (select all that apply):  If the case travelled **domestically**, does the case suspect that mpox was acquired outside their province of residence? | BC  QC  NL  AB  NB  YK  SK  NS  NT  MB  PE  NU  ON  Yes  No  Unknown  If yes, provide additional details about the suspected acquisition during domestic travel (e.g., did the case attend any mass gatherings): |
| If the case travelled outside of Canada, list the country(ies) visited:\*  If the case travelled **internationally**, does the case suspect that mpox was acquired abroad?  **If the case travelled internationally, please complete travel details in Section 9 on page 12\*.** | Yes  No  Unknown  If yes, provide additional details about the suspected acquisition during international travel (e.g., did the case attend any mass gatherings): |
| **Has the case had contact with anyone presenting similar symptoms; or with a known suspect, probable, or confirmed case of monkeypox, or with contaminated material (body fluids, object, bedding, etc.)?\*** | Yes  No  Unknown  **If yes, specify type of contact (select all that apply):**  Sexual and/or close intimate contact  Household (e.g., sharing bed, food, common space)  Providing care to someone  Other, specify:  **If yes, specify setting where the contact occurred (select all that apply)\*:**  Household (e.g., sharing bed, food, common space)  Workplace  School/nursery  Healthcare (including laboratory exposure)  Night club / private party / sauna or similar setting  Bar / restaurant or other small event  Large event (e.g., festival or sports event)  Transportation (airplane, cars, other private or public transit)  Other, specify (or any organized event, provide name, location, attendees, etc):  Unknown | |

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| **Below exposures refer to the period of 21 days prior to onset of symptoms or diagnosis** | | |
| **Has the case had any known contact with animals?\*** | Yes  No  Unknown | |
| **If yes, specify type of animal (select all that apply)\*** | **Animal type** | **Additional details** *(e.g. specify animal, approximate dates, location, type of contact, frequency of contact)* |
| Household pets, excluding rodents  *(e.g. dog, cat, rabbit, ferret, hedgehog, etc)* |  |
| Pet rodent  *(e.g. rat, mouse, hamster, guinea-pig, prairie dog, etc, including those in breeding facilities, raised as ‘feeders’ etc.)* |  |
| Farm animals  *(e.g. pig, cow, sheep, horse, etc)* |  |
| Wild animals, excluding wild rodents |  |
| Wild rodents  *(e.g. mouse, rat, squirrel, beaver, etc)* |  |
| ☐ Captive wildlife  *(e.g. zoo animals, animals in research facilities, etc., in particular non-human primates and rodents)* |  |
| Other/Unsure of classification |  |
| Unknown | |
| **Indicate other exposure settings where the case may have been exposed and acquired infection (select all that apply)**  *Exposure setting is based on local public health assessment (consider risk, likelihood of transmission, time spent at location, activity at that location, etc.)* | Acute care setting (e.g. hospital, emergency room)  Community healthcare setting (e.g. private clinics)  Congregate living setting (e.g. shelter, group homes, university dormitories, etc.)  Correctional facility  Mass gathering (*e.g. conference, festival, etc. A mass gathering is defined here as an aggregation of >1,000 people.*)  Occupational/Workplace, specify type:  Personal care setting (e.g. spa, hair salon, etc.)  Recent history of multiple or anonymous sexual partners  Recreational facility (e.g. gym, museum, community centre)  Sex-on-premises venue such as sauna / bathhouse / sex club / sex party  School (e.g. elementary, secondary, post-secondary) / Nursery / Daycare / Day camp  Social event (e.g. house party, family event, etc.)  Transportation (e.g. municipal transport system, taxi, etc.)  Restaurant / bar / nightclub  Other, specify:  Unknown  Declined to answer  **Additional details on exposure settings:** | |
| **Indicate methods and locations used for meeting sexual partners, if applicable (select all that apply)** | Bar / club  Sex-on-premises venue such as sauna / bathhouse / sex club / sex party  Cruising / public spaces (parks, streets, bathrooms, etc)  Dating apps, internet, online social network  Friends / family / school / work  Out of the province/territory, specify:  Other, specify (e.g. adult bookstore, correctional facility):  Unknown  Declined to answer | |
| **Indicate the gender(s) of sexual partner(s) (select all that apply)**\* | Woman  Man  Non-binary person  Unknown or undetermined  If none of the above, specify:  Not applicable | |
| **Describe any close contacts, including the approximate number, type or nature of contacts and any additional details:** | | |
| **Based on the previously reported information, which is the most likely mode of transmission?\*** | Animal to human transmission  Healthcare-associated  Transmission from mother to child during pregnancy or at birth  Person-to-person transmission via sexual contact  Person-to-person transmission **excluding** mother-to-child, healthcare-associated or sexual transmission  Contact with contaminated material (e.g. bedding, clothing, object)  Parenteral transmission including intravenous drug use and transfusion  Transmission in a laboratory due to occupational exposure  Other transmission, specify:  Unknown | |

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| **SECTION 7: LABORATORY RESULTS / INVESTIGATIONS** | | | | | | |
| **Monkeypox laboratory** | | | | | | |
| **Specimen collection date for monkeypox** | (*yyyy-mm-dd*)  ☐ Not applicable | | | | | |
| **Laboratory report date\*** | *(yyyy-mm-dd)*  ☐ Not applicable | | | | | |
| **What specimen(s) were analyzed for the diagnosis of the case? (select all that apply)\*** | Skin lesion material (including swabs of lesion surface, and/or exudate, roofs from more than one lesion)  Lesion crust  Oropharyngeal swab  Urine  Semen  Genital swab  Rectal swab  Serum  Other specimen, specify:  ☐ Not applicable | | | | | |
| **What laboratory methods were used to analyse the specimen(s) for diagnosis? (select all that apply)\*** | Positive monkey poxvirus-specific PCR  Positive orthopoxvirus PCR  Sequencing  Serology  Other (specify):  ☐ Not applicable | | | | | |
| **Indicate whether genomic characterization has been undertaken\*** | ☐ Yes  ☐ No  ☐ Unknown  ☐ Not applicable  **If sequencing conducted, indicate clade of monkeypox virus**  ☐ West African clade  ☐ Congo Basin clade  **Accession number of the sequence uploaded to public database**    ☐ Not applicable | | | | | |
| **Other laboratory testing (if available)** | | | | | | |
| **Test Name** | | **Result** | | | | **Specimen collection date**  ***(yyyy-mm-dd)*** |
| **Detected** | **Not detected** | **Not tested** | **Pending** |
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| **SECTION 8: ANY OTHER INFORMATION** | |
| **Are there any other remarkable events, interactions, or experiences in the 21 days prior to symptom onset that have not been reported so far that might be important or that you suspect may have caused or contributed to the illness?** | Yes  No  Unknown  Declined to answer  If yes, specify details: |

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| **SECTION 9: INTERNATIONAL TRAVEL HISTORY OF CONFIRMED CASES** | | | | | | |
| **If the case has been confirmed, has travelled internationally in the 21 days prior to symptom onset, and there is information to share through the International Health Regulations, please provide the following details** | | | | | | |
| **Plane** | **Airline and Flight Number** | **Origin and Destination** | **Row and Seat Number** | **Date of Departure** | **Date of Arrival** | **Other Notes** |
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| **Accommodation** | **Name of Hotel / Residence** | | **Location** | **Date (Start)** | **Date (End)** | **Other Notes** |
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| **Cruise** | **Name of Cruise Ship** | **Origin and Destination** | **Room Number** | **Sailing Date (Start)** | **Sailing Date (End)** | **Other Notes** |
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| **Conference/event/places visited** | **Name of Event / Event Space** | | **Location** | **Date (Start)** | **Date (End)** | **Other Notes** |
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| **Known International Contacts** | **Is there any information anticipated to be shared via the International Health Regulations such as name and contact information for known contacts residing outside of Canada?**  Yes  No  Unknown  Declined to answer | | | | | |
| **Additional details related to international travel** |  | | | | | |

**END OF QUESTIONNAIRE**

**Appendix – additional vaccine doses**

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| **Smallpox vaccination(s) received on or after May 1st, 2022** | **Dose Number**  **(Order by date administered)** | **Vaccine received** | | **Date administered (DD/MM/YYYY) or year administered if date unknown** | **Route of administration** | **Reason for vaccination** | **Country of vaccination** |
| **Dose 4** | ☐ Imvamune (Imvanex, Jynneos)  ☐ Other 3rd generation smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | ☐ subcutaneous  ☐ intradermal  ☐ unknown | ☐ other: | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 5** | ☐ Imvamune (Imvanex, Jynneos)  ☐ Other 3rd generation smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | ☐ subcutaneous  ☐ intradermal  ☐ unknown | ☐ other: | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 6** | ☐ Imvamune (Imvanex, Jynneos)  ☐ Other 3rd generation smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | ☐ subcutaneous  ☐ intradermal  ☐ unknown | ☐ other: | ☐ Canada  ☐ US  ☐ Other: |
| **Smallpox vaccination(s) received prior to May 1st, 2022** | **Dose Number**  **(Order by date administered)** | | **Vaccine received** | | **Date administered (DD/MM/YYYY) or year administered if date unknown** | | **Country of vaccination** |
| **Dose 4** | | ☐ ACAM2000  ☐ Other smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 5** | | ☐ ACAM2000  ☐ Other smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | | ☐ Canada  ☐ US  ☐ Other: |
| **Dose 6** | | ☐ ACAM2000  ☐ Other smallpox vaccine, please specify:  ☐ Other smallpox vaccine, name unknown | |  | | ☐ Canada  ☐ US  ☐ Other: |