



MONKEYPOX CASE REPORT FORM

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.

SECTION 2: ADMINISTRATIVE INFORMATION	
<input type="checkbox"/> Initial Report <input type="checkbox"/> Updated Report	
Reporting Province/Territory*	<input type="checkbox"/> BC <input type="checkbox"/> QC <input type="checkbox"/> YK <input type="checkbox"/> AB <input type="checkbox"/> NB <input type="checkbox"/> NT <input type="checkbox"/> SK <input type="checkbox"/> NS <input type="checkbox"/> NU <input type="checkbox"/> MB <input type="checkbox"/> PE <input type="checkbox"/> ON <input type="checkbox"/> NL
Forward Sortation Area (First 3 digits of postal code) OR Health region	

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	
Public health report date *	
Month/Year of birth OR * Age	years; if under 2 years, indicate in months: months
Sex assigned at birth*	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Prefer not to respond/disclose <input type="checkbox"/> Unknown
Gender identity* <small>Sex and gender based on StatCan</small>	<input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Non-binary person <input type="checkbox"/> If none of the above, then case identifies as: <input type="checkbox"/> Prefer not to respond/disclose <input type="checkbox"/> Unknown
Race <i>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</i>	<input type="checkbox"/> Black (African, African Canadian, Afro-Caribbean descent) <input type="checkbox"/> East Asian (Chinese, Japanese, Korean, Taiwanese descent) <input type="checkbox"/> Indigenous (First Nations, Inuk/Inuit, Métis, Other, please specify below) <input type="checkbox"/> Latin American (Hispanic or Latin American descent) <input type="checkbox"/> Middle Eastern (Arab, Persian, West Asian descent (e.g., Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish)) <input type="checkbox"/> South Asian (South Asian descent, e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan) <input type="checkbox"/> Southeast Asian (Southeast Asian descent, e.g. Cambodian, Filipino, Indonesian, Thai, Vietnamese, Laotian, Malaysian) <input type="checkbox"/> White (European descent) <input type="checkbox"/> Another race category, specify: <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to answer

<p>Indigenous identity</p> <p>Does the case identify as First Nations, Inuk/Inuit and/or Métis?</p> <p>Select all that apply</p>	<p><input type="checkbox"/> Yes, First Nations</p> <p><input type="checkbox"/> Yes, Métis</p> <p><input type="checkbox"/> Yes, Inuk/Inuit</p> <p><input type="checkbox"/> Other Indigenous, specify:</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Declined to answer</p>
<p>Dwelling type</p>	<p><input type="checkbox"/> Private dwelling (single family home)</p> <p><input type="checkbox"/> Private dwelling (apartment)</p> <p><input type="checkbox"/> Student residence</p> <p><input type="checkbox"/> Rooming house/group home</p> <p><input type="checkbox"/> Assisted living facility</p> <p><input type="checkbox"/> Long term care facility</p> <p><input type="checkbox"/> Retirement residence</p> <p><input type="checkbox"/> Correctional facility</p> <p><input type="checkbox"/> Shelter/homeless</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other, specify:</p>
<p>Is the case a healthcare worker?*</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
<p>If the case is a healthcare worker, what is the healthcare occupation of the case?</p>	<p><input type="checkbox"/> Administrative services</p> <p><input type="checkbox"/> Allied health professional (e.g. respiratory therapist, physiotherapist, social workers)</p> <p><input type="checkbox"/> Dental professional</p> <p><input type="checkbox"/> Emergency medical personnel</p> <p><input type="checkbox"/> Laboratory worker</p> <p><input type="checkbox"/> Nurse</p> <p><input type="checkbox"/> Pharmacist or pharmacy technician</p> <p><input type="checkbox"/> Physician</p> <p><input type="checkbox"/> Support services (e.g. cleaners, kitchen staff)</p> <p><input type="checkbox"/> Student</p> <p><input type="checkbox"/> Volunteer</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other, specify:</p>
<p>If case is not a healthcare worker or volunteer, indicate case's occupation</p>	<p><input type="checkbox"/> Animal worker/volunteer (e.g. animal shelter, wildlife rehabilitation, zoo, veterinary clinic), specify:</p> <p><input type="checkbox"/> Border services</p> <p><input type="checkbox"/> Cleaning/custodial services</p> <p><input type="checkbox"/> Correctional facility worker</p> <p><input type="checkbox"/> Farm worker</p> <p><input type="checkbox"/> Flight attendant</p> <p><input type="checkbox"/> Industrial worker (e.g. mining, construction, warehouse, factory)</p> <p><input type="checkbox"/> Law enforcement (e.g. police, RCMP)</p> <p><input type="checkbox"/> Restaurant/bar worker</p> <p><input type="checkbox"/> Retail worker (e.g. grocery, retail)</p> <p><input type="checkbox"/> Office worker</p> <p><input type="checkbox"/> Retired</p> <p><input type="checkbox"/> Sex worker</p> <p><input type="checkbox"/> School or daycare worker</p> <p><input type="checkbox"/> Works with homeless/under-housed population</p> <p><input type="checkbox"/> Student</p> <p><input type="checkbox"/> Unemployed</p> <p><input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Other, specify:</p>
<p>Case classification*</p>	<p><input type="checkbox"/> Confirmed</p> <p><input type="checkbox"/> Probable</p> <p><input type="checkbox"/> Suspect</p> <p><input type="checkbox"/> Does not meet definition (e.g., if ruled out after testing)</p>

SECTION 4: CLINICAL CASE PRESENTATION

Was the case hospitalized?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes:		
		Admission date		
		Discharge date		
If the case was hospitalized, what was the main reason for hospitalization?*	<input type="checkbox"/> Due to monkeypox illness <input type="checkbox"/> Clinically indicated for another reason <input type="checkbox"/> Need for isolation <input type="checkbox"/> Other, specify: <input type="checkbox"/> Unknown			
Was the case admitted to an intensive care unit or high dependency unit?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Outcome status at time of reporting*	<input type="checkbox"/> Recovered	Date of recovery		
	<input type="checkbox"/> In hospital			
	<input type="checkbox"/> Symptomatic at home			
	<input type="checkbox"/> Deceased	Date of death*		
	<input type="checkbox"/> Unknown	Cause of death, if known at time of reporting:		
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:*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Please provide the onset date of the first symptoms:*				
Symptom	Symptom present			Symptom onset date
	Yes	No	Unknown	
Fever*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Temperature: <input type="checkbox"/> Celsius <input type="checkbox"/> Fahrenheit			
Headache*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Myalgia/arthritis*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue/exhaustion*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please provide a summary of the signs and symptoms of the illness and dates of onset if known:				
Symptom	Symptom present			Symptom onset date (yyyy-mm-dd)
Swollen lymph nodes *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Specify location of adenopathy (select all that apply)*: <input type="checkbox"/> Submandibular <input type="checkbox"/> Cervical <input type="checkbox"/> Inguinal <input type="checkbox"/> Axillary <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify:			
Chills *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Conjunctivitis *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting/nausea *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rash/lesions*:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*
macular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
papular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
vesicular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
pustular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ulcerous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
crusted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Location(s) of the rash/lesions*: <input type="checkbox"/> Anogenital/perianal <input type="checkbox"/> Hands and palms of hand <input type="checkbox"/> Oral (mouth, lips, oral mucosa including throat) <input type="checkbox"/> Soles of feet <input type="checkbox"/> Face, excluding oral and mucosal surfaces <input type="checkbox"/> Torso <input type="checkbox"/> Limbs (arms, legs) <input type="checkbox"/> Other, specify:				
Number of lesions: <input type="checkbox"/> One lesion <input type="checkbox"/> 50-100 lesions <input type="checkbox"/> 2-10 lesions <input type="checkbox"/> >100 lesions <input type="checkbox"/> 10-50 lesions <input type="checkbox"/> Unknown				
Other symptom, specify:				
Other symptom, specify:				
Other symptom, specify:				
Other symptom, specify:				
Other symptom, specify:				

Please provide a summary of the signs and symptoms of the illness and dates of onset if known:					
Were any of the following complications reported?					
	Yes	No	Unknown	Declined to Answer	
Secondary infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Corneal infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchopneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sepsis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcerative lesion with delayed healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Myocarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other, specify:					

SECTION 5: MEDICAL RISK FACTORS / HISTORY		
Please provide a summary of vaccination and treatment		
	Risk factor/history present	Details
Ever received the smallpox vaccine *	<input type="checkbox"/> Yes – previous vaccination unrelated to current event <input type="checkbox"/> Yes – pre-exposure prophylaxis for current event <input type="checkbox"/> Yes – post-exposure prophylaxis for current event <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of last vaccination, if known *: <input type="checkbox"/> Documented immunisation <input type="checkbox"/> Undocumented immunisation
	If yes, the name of vaccine: <input type="checkbox"/> ACAM2000 <input type="checkbox"/> Imvamune (Imvanex/Jynneos) <input type="checkbox"/> Other vaccine, specify: <input type="checkbox"/> Other smallpox vaccine, name unknown	Additional details:
Antiviral treatment received for monkeypox *	Did the case receive antiviral treatment for monkeypox? <input type="checkbox"/> Yes (please specify below) <input type="checkbox"/> No antiviral treatment <input type="checkbox"/> Unknown If yes, which antiviral treatment was received? <input type="checkbox"/> Tecovirimat <input type="checkbox"/> Brincidofovir <input type="checkbox"/> Cidofovir <input type="checkbox"/> The name of antiviral treatment not known <input type="checkbox"/> Other, specify:	

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

SECTION 6: RISK FACTORS / EXPOSURE HISTORY

Below exposures refer to the period of 21 days prior to onset of symptoms or diagnosis

<p>Has the case had any day trips, travel and/or overnight visits to other locations outside of the province of residence or Canada?*</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of departure: Date of return:															
	If the case travelled within Canada, specify province, territory (select all that apply): <table border="0" style="width: 100%;"> <tr> <td><input type="checkbox"/> BC</td> <td><input type="checkbox"/> QC</td> <td><input type="checkbox"/> NL</td> </tr> <tr> <td><input type="checkbox"/> AB</td> <td><input type="checkbox"/> NB</td> <td><input type="checkbox"/> YK</td> </tr> <tr> <td><input type="checkbox"/> SK</td> <td><input type="checkbox"/> NS</td> <td><input type="checkbox"/> NT</td> </tr> <tr> <td><input type="checkbox"/> MB</td> <td><input type="checkbox"/> PE</td> <td><input type="checkbox"/> NU</td> </tr> <tr> <td><input type="checkbox"/> ON</td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/> BC	<input type="checkbox"/> QC	<input type="checkbox"/> NL	<input type="checkbox"/> AB	<input type="checkbox"/> NB	<input type="checkbox"/> YK	<input type="checkbox"/> SK	<input type="checkbox"/> NS	<input type="checkbox"/> NT	<input type="checkbox"/> MB	<input type="checkbox"/> PE	<input type="checkbox"/> NU	<input type="checkbox"/> ON		
	<input type="checkbox"/> BC	<input type="checkbox"/> QC	<input type="checkbox"/> NL													
<input type="checkbox"/> AB	<input type="checkbox"/> NB	<input type="checkbox"/> YK														
<input type="checkbox"/> SK	<input type="checkbox"/> NS	<input type="checkbox"/> NT														
<input type="checkbox"/> MB	<input type="checkbox"/> PE	<input type="checkbox"/> NU														
<input type="checkbox"/> ON																
If the case travelled outside of Canada, list the country(ies) visited: * If the case travelled internationally, please complete travel details in Section 9 on page 12*.																
<p>Has the case had contact with <u>anyone presenting similar symptoms; or with a known suspect, probable, or confirmed case of monkeypox, or with contaminated material (body fluids, object, bedding, etc.)?*</u></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify type of contact (select all that apply): <input type="checkbox"/> Sexual and/or close intimate contact <input type="checkbox"/> Household (e.g., sharing bed, food, common space) <input type="checkbox"/> Providing care to someone <input type="checkbox"/> Other, specify: If yes, specify setting where the contact occurred (select all that apply)*: <input type="checkbox"/> Household (e.g., sharing bed, food, common space) <input type="checkbox"/> Workplace <input type="checkbox"/> School/nursery <input type="checkbox"/> Healthcare (including laboratory exposure) <input type="checkbox"/> Night club / private party / sauna or similar setting <input type="checkbox"/> Bar / restaurant or other small event <input type="checkbox"/> Large event (e.g., festival or sports event) <input type="checkbox"/> Transportation (airplane, cars, other private or public transit) <input type="checkbox"/> Other, specify (or any organized event, provide name, location, attendees, etc): <input type="checkbox"/> Unknown															

Has the case had any known contact with animals?*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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)
	<input type="checkbox"/> Household pets, excluding rodents <i>(e.g. dog, cat, rabbit, ferret, hedgehog, etc)</i>	
	<input type="checkbox"/> Pet rodent <i>(e.g. rat, mouse, hamster, guinea-pig, prairie dog, etc, including those in breeding facilities, raised as 'feeders' etc.)</i>	
	<input type="checkbox"/> Farm animals <i>(e.g. pig, cow, sheep, horse, etc)</i>	
	<input type="checkbox"/> Wild animals, excluding wild rodents	
	<input type="checkbox"/> Wild rodents <i>(e.g. mouse, rat, squirrel, beaver, etc)</i>	
	<input type="checkbox"/> Captive wildlife <i>(e.g. zoo animals, animals in research facilities, etc., in particular non-human primates and rodents)</i>	
	<input type="checkbox"/> Other/Unsure of classification	
Indicate other exposure settings where the case may have been exposed and acquired infection (select all that apply) <i>Exposure setting is based on local public health assessment (consider risk, likelihood of transmission, time spent at location, activity at that location, etc.)</i>	<input type="checkbox"/> Acute care setting (e.g. hospital, emergency room) <input type="checkbox"/> Community healthcare setting (e.g. private clinics) <input type="checkbox"/> Congregate living setting (e.g. shelter, group homes, university dormitories, etc.) <input type="checkbox"/> Correctional facility <input type="checkbox"/> Mass gathering (e.g. conference, festival, etc. A mass gathering is defined here as an aggregation of >1,000 people.) <input type="checkbox"/> Occupational/Workplace, specify type: <input type="checkbox"/> Personal care setting (e.g. spa, hair salon, etc.) <input type="checkbox"/> Recent history of multiple or anonymous sexual partners <input type="checkbox"/> Recreational facility (e.g. gym, museum, community centre) <input type="checkbox"/> Sex-on-premises venue such as sauna / bathhouse / sex club / sex party <input type="checkbox"/> School (e.g. elementary, secondary, post-secondary) / Nursery / Daycare / Day camp <input type="checkbox"/> Social event (e.g. house party, family event, etc.) <input type="checkbox"/> Transportation (e.g. municipal transport system, taxi, etc.) <input type="checkbox"/> Restaurant / bar / nightclub <input type="checkbox"/> Other, specify: <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to answer Additional details on exposure settings:	
Indicate methods and locations used for meeting sexual partners, if applicable (select all that apply)	<input type="checkbox"/> Bar / club <input type="checkbox"/> Sex-on-premises venue such as sauna / bathhouse / sex club / sex party <input type="checkbox"/> Cruising / public spaces (parks, streets, bathrooms, etc) <input type="checkbox"/> Dating apps, internet, online social network <input type="checkbox"/> Friends / family / school / work <input type="checkbox"/> Out of the province/territory, specify: <input type="checkbox"/> Other, specify (e.g. adult bookstore, correctional facility): <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to answer	

Indicate the gender(s) of sexual partner(s) (select all that apply)*	<input type="checkbox"/> Woman <input type="checkbox"/> Man <input type="checkbox"/> Non-binary person <input type="checkbox"/> Unknown or undetermined <input type="checkbox"/> If none of the above, specify: <input type="checkbox"/> 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?*	<input type="checkbox"/> Animal to human transmission <input type="checkbox"/> Healthcare-associated <input type="checkbox"/> Transmission from mother to child during pregnancy or at birth <input type="checkbox"/> Person-to-person transmission via sexual contact <input type="checkbox"/> Person-to-person transmission excluding mother-to-child, healthcare-associated or sexual transmission <input type="checkbox"/> Contact with contaminated material (e.g. bedding, clothing, object) <input type="checkbox"/> Parenteral transmission including intravenous drug use and transfusion <input type="checkbox"/> Transmission in a laboratory due to occupational exposure <input type="checkbox"/> Other transmission, specify: <input type="checkbox"/> Unknown

SECTION 7: LABORATORY RESULTS / INVESTIGATIONS	
Monkeypox laboratory	
Specimen collection date for monkeypox	<input type="checkbox"/> Not applicable
Laboratory report date*	<input type="checkbox"/> Not applicable
What specimen(s) were analyzed for the diagnosis of the case? (select all that apply)*	<input type="checkbox"/> Skin lesion material (including swabs of lesion surface, and/or exudate, roofs from more than one lesion) <input type="checkbox"/> Lesion crust <input type="checkbox"/> Oropharyngeal swab <input type="checkbox"/> Urine <input type="checkbox"/> Semen <input type="checkbox"/> Genital swab <input type="checkbox"/> Rectal swab <input type="checkbox"/> Serum <input type="checkbox"/> Other specimen, specify: <input type="checkbox"/> Not applicable

SECTION 7: LABORATORY RESULTS / INVESTIGATIONS

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
	Detected	Not detected	Not tested	Pending	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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:

SECTION 9: INTERNATIONAL TRAVEL HISTORY

If the case travelled internationally in the 21 days prior to symptom onset, 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
Accommodation	Name of Hotel / Residence		Location	Date (Start)	Date (End)	Other Notes
Cruise	Name of Cruise Ship	Origin and Destination	Room Number	Sailing Date (Start)	Sailing Date (End)	Other Notes
Conference/event/ places visited	Name of Event / Event Space		Location	Date (Start)	Date (End)	Other Notes
Known International Contacts	<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to answer</p>					
Additional details related to international travel						

END OF QUESTIONNAIRE