



**DATE:** DD / MM / YYYY

## CASE INVESTIGATION FORM: TANAPOX

### I. PATIENT DETAILS

Surname:		Name/s:		
Date of birth:	DD / MM / YYYY	Age:	Sex:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Contact Tel./Cell:		Occupation:		
Physical home/work address:				

### II. ATTENDING HEALTHCARE WORKER AND HEALTHCARE FACILITY DETAILS

Name of clinician:		Contact Tel./Cell clinician:	(000) 0000000
Healthcare facility name:		Location of healthcare facility:	

### III. RISK FACTORS/ EXPOSURE HISTORY – during the 14 days prior to onset of symptoms

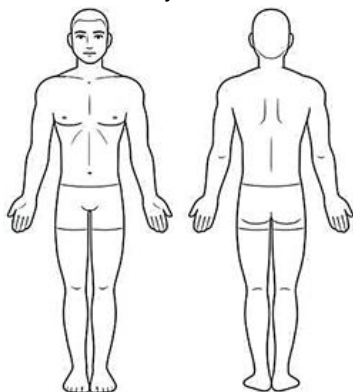
Have you been in a wildlife area?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Were you near water bodies? (rivers, dams, water holes)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Were you bitten by mosquitoes/other insects/ticks?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Were there vervet monkeys close by?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>
Were there any baboons close by?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>

### IV. CLINICAL FEATURES

#### A. LESIONS

When did the first lesion appear? DD / MM

Mark the body site of the lesion:



If other lesions appeared, please mark the body sites of these numerically in order of appearance.

Describe the lesion/s' appearance: [Click or tap here to enter text.](#)

#### B. OTHER SYMPTOMS

				onset	duration
Fever (>37.5°C)	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	
Headache	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	
Lesion pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	
Muscle pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	
Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	
Pruritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	
Rash	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	
Inflammation	Yes <input type="checkbox"/>	No <input type="checkbox"/>		DD / MM	

### V. PAST MEDICAL and TRAVEL HISTORY

Underlying illness (including any immunosuppressing condition e.g. active HIV disease, diabetes)? Yes  No  Unknown

If yes, give details:

Country/ies visited:	Location/s visited within country:	Arrival date DD / MM / YYYY	Departure date DD / MM / YYYY
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Activities at the location and purpose of travel:

**SUBMIT COMPLETED FORM WITH SPECIMEN TO:** Special Viral Pathogens Lab, National Institute for Communicable Diseases, National Health Laboratory Service, 1 Modderfontein Road, Sandringham 2192, South Africa

**EMAIL COMPLETED FORM TO:** [jacquelinew@nicd.ac.za](mailto:jacquelinew@nicd.ac.za) / [naazneenm@nicd.ac.za](mailto:naazneenm@nicd.ac.za) / [outbreak@nicd.ac.za](mailto:outbreak@nicd.ac.za)