***EMERGE*ncy ID NET CRASHED Project**

**Health Care Utilization Form**

*Complete this form for every* ***MPox-related health care visit*** *after enrollment for only for those with a positive Mpox test at any time during the project. If the participant received care at another facility, please attempt to retrieve their records and complete this form.*

1. Select visit type where care/tests were received:

 [ ]  Emergency department

 [ ]  Primary care

 [ ]  STD clinic

 [ ]  Dermatologist

 [ ]  Urgent Care

 [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Select the facility location:

[ ]  Enrollment Site (Project Site)

[ ]  Outside Facility, please specify name of facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Specify dates of care:

Start date of care: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ mm/dd/yyyy

End date of care: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ \_\_ \_\_ mm/dd/yyyy

1. Was the participant hospitalized at this visit?

 [ ]  Yes

 [ ]  No

1. Please specify reasons for visit (*mark all that apply*):

 [ ]  Follow up visit, improving symptoms

 [ ]  Pain at rash site

 [ ]  Ongoing rash

 [ ]  New rash at different site

 [ ]  Skin infection (secondary SSTI)

 [ ]  Sexually transmitted infection

 [ ]  Fevers

 [ ]  Fatigue/generalized weakness

 [ ]  Body aches

 [ ]  Swollen lymph nodes

 [ ]  Headaches

 [ ]  Pneumonia

 [ ]  Eye infection

 [ ]  Proctitis

 [ ]  Dehydration

 [ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| 1. Did the participant receive Mpox test at this visit?
 | [ ]  Yes [ ]  No |
|  6a. If Yes, note result: [ ]  Positive [ ]  Negative/Indeterminate |

1. Were any of the following STI tests performed? (check all that apply; if Yes, indicate positive or negative/indeterminate)
 |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **No** | **Yes** | **Positive** | **Negative/indeterminate** |
| Chlamydia | [ ]  | [ ]  | [ ]  | [ ]  |
| Gonorrhea | [ ]  | [ ]  | [ ]  | [ ]  |
| Syphilis | [ ]  | [ ]  | [ ]  | [ ]  |
| Herpes | [ ]  | [ ]  | [ ]  | [ ]  |
| HPV | [ ]  | [ ]  | [ ]  | [ ]  |
| HIV | [ ]  | [ ]  | [ ]  | [ ]  |
| Trichomonas  | [ ]  | [ ]  | [ ]  | [ ]  |

 |
|  |
| 1. Were any of the following treatments provided? (check all that apply)

 [ ]  None of the following [ ]  Antibiotics: if Yes, please check all that apply:  [ ]  Clindamycin [ ]   [ ]  [ ]  TMP/SMX [ ]   [ ]  [ ]  Oxacillin/Nafcillin [ ]   [ ]  [ ]  Doxycycline [ ]  [ ]  [ ]  Piperacillin/Tazobactam  [ ]  [ ]  Cephalexin  [ ]  Vancomycin [ ]  Cefazolin [ ]  Ceftriaxone  [ ]  Other (*specify*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Acyclovir/Valacyclovir  [ ]  Steroids (dexamethasone, methylprednisolone, prednisone, hydrocortisone, triamcinolone) [ ]  Tecovirimat (TPOXX) |

1. What was the discharge/admit diagnosis?

(*check all that apply and if other conditions not listed below apply, then check “other” and list the one additional diagnosis*)

[ ]  [ ]  Rash

[ ]  [ ]  Shingles

[ ]  [ ]  Herpes simplex

[ ]  [ ]  Contact dermatitis

[ ]  [ ]  Allergic reaction

[ ]  [ ]  Eczema

[ ]  [ ]  Hand, foot, mouth disease

[ ]  [ ]  Cellulitis

[ ]  [ ]  Arthropod bite (insect bite)

[ ]  [ ]  Scabies

[ ]  [ ]  URI/influenza/influenza-like illness/viral syndrome

[ ]  [ ]  MPox

[ ]  [ ]  Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Note: You do not need to record underlying conditions (e.g., diabetes, HTN)*

Comments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Form Completed by MM DD YYYY