***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