# Monkeypox Consultation Form

To better prioritize referrals for outside testing for Monkeypox, the Jefferson County Department of Health requires additional information prior to accepting a referral for Monkeypox testing from an external provider.

Several National Laboratories currently offer Monkeypox testing and the supplies to collect these are readily available. Information on specimen collection can be found at: https://www.alabamapublichealth.gov/monkeypox/assets/mpx-specimen-guidance.pdf. External providers can screen and test patients in their office without going through the health department.

If you choose to refer a patient to the Jefferson County Department of Health for evaluation, please note this form must be completed before a disposition for testing is determined. **All fields are required.** If not complete, we will notify the provider listed on the referral via e-mail. Once a completed referral is submitted, a disposition for testing will be sent to the provider. The referring provider is responsible for notifying the patient of the date and time of the appointment.

The two-page form and images of lesions must be submitted via secure and encrypted email to david.hicks@jcdh.org or faxed confidential to (205) 930-0243.

****PLEASE NOTE ALL FIELDS ARE REQUIRED. ****

| **PROVIDER INFORMATION** | |
|---|---|
| First and Last Name | Practice/Facility Name |
| Provider Direct Contact Phone Number | Provider Email Address |
| Provider After Hours Phone Number | Practice/Facility Address |

| **PERSONAL INFORMATION ABOUT PATIENT** | | | | |
|---|---|---|---|---|
| Last Name | | First Name | M.I. | Gender (Circle)<br><br>Male<br>Female<br>Transgender Male<br>Transgender Female |
| Date of Birth | Age | Race (Circle All that Apply): American Indian or Alaskan Native Asian or Pacific Islander<br>Black or African American White or Caucasian Unknown<br>Other | | |
| | | Ethnicity: (Circle) Hispanic/Latino Non- Hispanic Unknown | | |
| Telephone Number | Alternate Number | Street Address | | Apt. Number |
| City | County | State | | Zip Code |

| **PATIENT INSURANCE INFORMATION** | | | |
|---|---|---|---|
| Name of Insurance Company | Member ID Number/Contract Number | Group Number | Relationship to Subscriber (select)<br>☐ Self ☐ Spouse ☐<br>Other _____ |
| Subscriber Name (if different than patient) | Subscriber Birthdate | Subscriber Street Address, City, State, and Zip Code | |
| Secondary Insurance | Member ID /Contract Number | Group Number | Subscriber Name |

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Patient Name _____ Date of Birth _____

****PLEASE NOTE ALL FIELDS ARE REQUIRED. ****

| **Answer the following questions related to the patient by checking the appropriate box:** | **Yes** | **No** |
|---|---|---|
| Is patient associated with a correctional facility? If yes provide name of facility: | | |
| Is the patient a healthcare worker? | | |
| Has the patient had exposure to monkeypox in the past 14 days? | | |
| Does the patient have someone living in your household who has a confirmed case of monkeypox? | | |
| Has the patient had close, intimate contact with someone who tested positive for monkeypox in the last 14 days? | | |
| Is the patient a sex worker or employed in a sex work industry? | | |
| Is the patient gay, bisexual, transgender, gender non-conforming, gender non-binary, or other male who had male-to-male sexual contact? | | |
| Has the patient had fever of 100.4 F or higher | | |
| Has the patient had a macular rash (generalized or localized, discrete or confluent)? | | |
| Has the patient had a papular rash (generalized or localized, discrete or confluent)? | | |
| Has the patient had a vesicular rash (generalized or localized, discrete or confluent)? | | |
| Has the patient had a pustular rash (generalized or localized, discrete or confluent)? | | |
| Has the patient had chills? | | |
| Has the patient had sweats? | | |
| Has the patient had periauricular lymphadenopathy? | | |
| Has the patient had axillary lymphadenopathy? | | |
| Has the patient had cervical lymphadenopathy? | | |
| Has the patient had inguinal lymphadenopathy? | | |
| When did the patient start feeling ill? DATE: | | |
| Was the patient hospitalized for this illness? | | |
| How many sexual partners has the patient had in the last 30 days? | Number: | |
| How many sexual partners has the patient had in the last 6 months? | Number: | |
| Does the patient have sex with: (circle) MEN WOMEN BOTH | | |

**Please submit images of patient lesions.**

Please provide other information relevant to the case:

Provider Signature _____ Date _____