

Form 9

Case Investigation Report

Date of investigation	_____ (DD/MM/YY) Time: _____	Affiliation of investigator	
Name of investigator		Contact number of Investigator	
Reporting hospital/clinic		Date of reporting	_____ (DD/MM/YY)
		Contact number of reporting hospital/clinic	

1. Personal Information

Enter the personal information of the case subject to this case investigation and fill in the blank.

1.1 Name		1.2 Nationality (based on the passport)	
1.3 Date of birth	(For foreign nationals, enter your passport number)	1.4 Gender and age	○ Male ○ Female (Age: _____)
1.5 Occupation		1.6 Contact number (yourself)	
1.7 Name of workplace (School)		1.8 Contact number (family caretaker)	
1.9 Address	Address on your resident registration record card: Current place of residence: _____		

2. Clinical Symptoms

Choose any clinical symptoms and signs that you developed from the initial onset until the time of investigation and fill in the blanks.

2.1 Initial symptoms and date of onset	Date of initial symptoms onset: _____ (DD/MM/YY) / Symptoms: _____		
2.2 Current symptoms and signs (Choose all your conditions)	<input type="checkbox"/> General symptoms <input type="checkbox"/> Skin Lesions (rashes)	<input type="checkbox"/> Fever (_____ °C) <input type="checkbox"/> Sweating <input type="checkbox"/> Sore throat <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Swollen lymph nodes [<input type="checkbox"/> Cervical (neck) <input type="checkbox"/> Axillary (armpit) <input type="checkbox"/> Inguinal (groin)] <input type="checkbox"/> Headache <input type="checkbox"/> Muscle ache <input type="checkbox"/> Backache <input type="checkbox"/> Asthenia (weakness) <input type="checkbox"/> Fatigue <input type="checkbox"/> Itch <input type="checkbox"/> Keratitis <input type="checkbox"/> Vomiting or nausea <input type="checkbox"/> Other (_____)	Onset of symptoms: _____ (DD/MM/YY) Time: _____ <input type="checkbox"/> Macules (spots) <input type="checkbox"/> Papules (inflamed bumps) <input type="checkbox"/> Vesicles (blisters) <input type="checkbox"/> Pustules (pus blisters) <input type="checkbox"/> Scabs <input type="checkbox"/> Face <input type="checkbox"/> Trunk <input type="checkbox"/> Limbs <input type="checkbox"/> Palms of hands <input type="checkbox"/> Soles of the feet <input type="checkbox"/> Genitals <input type="checkbox"/> Anal <input type="checkbox"/> Other (_____) First site of skin lesions: (_____) Sites of skin lesions spread (_____) <input type="checkbox"/> Pain on skin lesions <input type="checkbox"/> Itch on skin lesions <input type="checkbox"/> Lesions on a single site of the body are relatively the same size and same stages of development (eg. pustules on the face, vesicles on the legs, etc.) <input type="checkbox"/> Well-circumscribed and deep-seated, often with central umbilication <input type="checkbox"/> Bleeding in skin lesions
2.3 Symptoms development in order	① Symptom (_____), Date of onset (_____) ② Symptom (_____), Date of onset (_____) ③ Symptom (_____), Date of onset (_____)		
2.4 Medication history (within the past 6 months)	<input type="radio"/> Yes <input type="checkbox"/> Name of medication: _____ <input type="checkbox"/> ① Start Date: _____ (DD/MM/YY) ② End Date: _____ (DD/MM/YY) <input type="checkbox"/> Reasons for taking the medication: _____ <input type="radio"/> No		
2.5 Health condition	2.5.1 Health	<input type="radio"/> Alive	

/History of treatment at a hospital/clinic (within the past 3 weeks)	condition	<input type="radio"/> Dead <input checked="" type="checkbox"/> Only in this case, the questions below should be asked		
	Date of death:	_____ (DD/MM/YY)		Place of death: <input type="radio"/> Hospital/clinic <input type="radio"/> Place of residence <input type="radio"/> Other ()
	2.5.2 treatment history at a hospital/clinic	<input type="radio"/> No <input type="radio"/> Yes <input checked="" type="checkbox"/> Only in this case, the questions below should be asked.		
	Type of treatment(+)	Name of hospital/clinic	Date/period	ICU Admission
	<input type="radio"/> Outpatient care <input type="radio"/> Emergency room <input type="radio"/> Inpatient care		~	<input type="radio"/> Yes <input type="radio"/> No
	<input type="radio"/> Outpatient care <input type="radio"/> Emergency room <input type="radio"/> Inpatient care		~	<input type="radio"/> Yes <input type="radio"/> No
2.6 History of smallpox vaccination	<input type="radio"/> Yes (<input checked="" type="checkbox"/> Date of vaccination: _____) <input type="radio"/> No <input type="radio"/> Not knowing			
2.7 Underlying conditions	<input type="radio"/> Yes (<input checked="" type="checkbox"/> Specify: _____) <input type="radio"/> No			
2.8 Immunocompromising conditions (Congenital or acquired)	<input type="radio"/> Yes (Date of initial diagnosis: _____ (DD/MM/YY), Specify: _____) <input type="radio"/> None <input type="radio"/> Not knowing			
2.9 Pregnancy status	<input type="radio"/> Yes <input type="radio"/> No <input checked="" type="checkbox"/> If yes, your gestational age is _____ weeks. Your expected date of delivery is _____ (DD/MM/YY)			
2.10 Differential diagnosis	If you have been diagnosed with having multiple conditions sharing the same symptoms as monkeypox, specify such conditions: _____ (e.g. chickenpox, shingles, measles, scabies, syphilis, malaria, etc.) If you have other medical conditions, specify such conditions: _____ _____)			

3. Travel history	<input checked="" type="checkbox"/> Choose any items and fill in the blanks below, regarding your travel history that occurred within 21 days prior to symptom onset				
3.1 Travel history (within the past 21 days)	<input type="checkbox"/> Yes (If yes, please fill in the blanks below in Section 3. Travel history) <input type="checkbox"/> None (Move to Section 4. Risk Exposure)				
3.2 Arrival and departure information (to and from South Korea)	Date of departure (from South Korea)	_____ (DD/MM/YY)			
	Date of arrival (to South Korea)	_____ (DD/MM/YY)		Time: _____	
	Means of transport	<input type="checkbox"/> Aircraft (Flight number: _____ Airline: _____ Seat number: _____) <input type="checkbox"/> Ship (IMO ship ID: _____ Shipping line: _____ Location where most time you stayed in the ship: _____)			
3.3 Visiting countries and cities / period of stay	Visiting countries	Cities	Period of stay	Flight transit in airport	Monkeypox endemic country/ outbreak country
			~	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			~	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			~	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

			~	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
			~	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3.4 Accompanied	<input type="radio"/> Solo travel/visit <input type="radio"/> Accompanied by two or more persons (No. of your accompanying persons such as family members, co-workers, etc.:)				
3.5 Purpose of your visit	<input type="radio"/> Friendship promotion/social gatherings/hobbies <input type="radio"/> Travel/sightseeing <input type="radio"/> Business <input type="radio"/> Missionary activities <input type="radio"/> Medical volunteering and relief activities <input type="radio"/> Work/residence <input type="radio"/> Other ()				

4. Risk Exposure	☞ Choose any items and fill in the blanks, regarding your risk exposure that occurred within 21 days prior to symptom onset																	
4.1 History of contact with suspected or confirmed monkeypox cases	Do you have any experience of contact with a suspected or confirmed monkeypox case? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not knowing <div> <div>☞ If yes,</div> <div> Relationship with the case: _____ Date and time of contact : _____ Place of contact: _____ Exposure setting: <input type="radio"/> Household contact <input type="radio"/> Stay in the same place <input type="radio"/> Physical contact <input type="radio"/> Other () </div> </div>																	
4.2 History of exposure to a risk environment	☞ Specify below <table border="1"> <thead> <tr> <th>Details of exposure</th> <th>Place/areas</th> <th>Date and time</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Participation in large events</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Laboratory exposure (work or temporary visits)</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Specimens handling such as collection, transport, etc.</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other ()</td> <td></td> <td></td> </tr> </tbody> </table>			Details of exposure	Place/areas	Date and time	<input type="checkbox"/> Participation in large events			<input type="checkbox"/> Laboratory exposure (work or temporary visits)			<input type="checkbox"/> Specimens handling such as collection, transport, etc.			<input type="checkbox"/> Other ()		
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4.3 Animal exposure	Do you have any experience of contact with livestock or wild animals? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not knowing <div> <div>☞ If yes,</div> <div> Animal (specific): _____ Date of contact: _____ Place of contact: _____ Source of contact: <input type="checkbox"/> Pet (rodents, etc.) <input type="checkbox"/> Wild animal carcass <input type="checkbox"/> Wild animals <input type="checkbox"/> Other () </div> </div>																	
4.4 Sexual contact (within the past 3 weeks)	Do you have any experience of sexual contact within 21 days prior to symptom onset? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not knowing <input type="radio"/> Refuse to answer <div> <div>☞ If yes,</div> <div> Number of sexual partners: <input type="radio"/> 1 <input type="radio"/> 2 or more <input type="radio"/> Refuse to answer Relationship with your sexual partner(s): <input type="radio"/> Spouse <input type="radio"/> Acquaintances <input type="radio"/> by chance <input type="radio"/> Refuse to answer </div> </div>																	
4.5 Blood transfusion / blood donation	Do you have any experience of blood donation or blood transfusion within 21 days prior to symptom onset? <input type="radio"/> Yes <input type="radio"/> No <div> <div>☞ If yes,</div> <div> <input type="checkbox"/> Donated Place: _____ Date: _____(DD/MM/YY) <input type="checkbox"/> Received Place: _____ Date: _____(DD/MM/YY) </div> </div>																	
4.6 Other suspected exposures	Specify:																	

5. Case classification and Management

Choose or fill in the blanks below.

5.1 Date of the case reported	_____ (DD/MM/YY) Time: _____															
5.2 Outcome of case classification	Epidemiological links	<input type="radio"/> Yes (visited an outbreak country or confirmed to have been exposed to risks) <input type="radio"/> No (not visited an outbreak country)														
	Clinical symptoms and signs	<input type="radio"/> Meet the definition of a suspected or confirmed case. <input type="radio"/> Fail to meet the definition of a suspected or confirmed case.														
	Outcome of case classification	<input type="radio"/> Suspected case <input type="radio"/> Not a case														
<Note on case classification> <div style="border: 1px solid black; padding: 5px; display: inline-block;"> ★ Admitted in the isolated ward and subject to testing </div>	<table border="1" style="width: 100%; text-align: center;"> <tr> <th colspan="2" rowspan="2">Classification</th> <th colspan="2">Clinical symptoms and signs of monkeypox</th> </tr> <tr> <th>Meet clinical criteria</th> <th>Fail to meet clinical criteria (Atypical symptoms)</th> </tr> <tr> <td rowspan="2">Epidemiological links (Risk levels)</td> <td>Presence</td> <td>Suspected case</td> <td>Not applicable</td> </tr> <tr> <td>Absence</td> <td>Not applicable</td> <td>Not applicable</td> </tr> </table> <p>※ Even though a person does not have any epidemiological link to a confirmed case or other cases, the person can be classified as a suspected case by diagnosis of medical professionals in infectious disease, proctology, urology, and dermatology. However, epidemiological investigation teams from local governments and regional Centres for Disease Control and Prevention should reconfirm epidemiological links, differential diagnosis, etc. specified in this Case Investigation Report, regarding the person.</p>			Classification		Clinical symptoms and signs of monkeypox		Meet clinical criteria	Fail to meet clinical criteria (Atypical symptoms)	Epidemiological links (Risk levels)	Presence	Suspected case	Not applicable	Absence	Not applicable	Not applicable
Classification		Clinical symptoms and signs of monkeypox														
		Meet clinical criteria	Fail to meet clinical criteria (Atypical symptoms)													
Epidemiological links (Risk levels)	Presence	Suspected case	Not applicable													
	Absence	Not applicable	Not applicable													
5.3 Patient transfer	Patient transfer	<input type="radio"/> Transfer <input type="radio"/> NOT necessary (because the hospital has isolation bed units) <input type="radio"/> NOT eligible (not a case)														
	Means of transport	<input type="radio"/> Public Health Center <input type="radio"/> Quarantine Station <input type="radio"/> 119 ambulance <input type="radio"/> Other: _____														
5.4 Quarantine/isolation	Place of quarantine/isolation	<input type="radio"/> Government-designated inpatient treatment beds <input type="radio"/> Negative pressure isolation beds in hospitals <input type="radio"/> Other (specify: _____)														
	Name of the hospital	_____														
	Start date of quarantine/isolation	_____ (DD/MM/YY) Time: _____														

6. Laboratory test

Choose any items below

6.1 Diagnostic tests	<input type="radio"/> Performed <input type="radio"/> Not performed			
Types of specimens	Specimens (+)	Date of specimen collection	Laboratory test performing agencies	Test results
	<input type="radio"/> Skin lesion fluid <input type="radio"/> Not performed	_____ (DD/MM/YY)	<input type="radio"/> Korea Disease Control and Prevention Agency <input type="radio"/> Public Health and Environment Research Institute	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> In progress <input type="radio"/> Other ()

	<input type="radio"/> Skin lesion tissues <input type="radio"/> Not performed	(DD/MM/YY)	<input type="radio"/> Korea Disease Control and Prevention Agency <input type="radio"/> Public Health and Environment Research Institute	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> In progress <input type="radio"/> Other ()
	<input type="radio"/> Scab <input type="radio"/> Not performed	(DD/MM/YY)	<input type="radio"/> Korea Disease Control and Prevention Agency <input type="radio"/> Public Health and Environment Research Institute	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> In progress <input type="radio"/> Other ()
	<input type="radio"/> Oropharyngeal swabs <input type="radio"/> Not performed	(DD/MM/YY)	<input type="radio"/> Korea Disease Control and Prevention Agency <input type="radio"/> Public Health and Environment Research Institute	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> In progress <input type="radio"/> Other ()
	<input type="radio"/> Blood <input type="radio"/> Not performed	(DD/MM/YY)	<input type="radio"/> Korea Disease Control and Prevention Agency <input type="radio"/> Public Health and Environment Research Institute	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> In progress <input type="radio"/> Other ()
	<input type="radio"/> Other () <input type="radio"/> Not performed	(DD/MM/YY)	<input type="radio"/> Korea Disease Control and Prevention Agency <input type="radio"/> Public Health and Environment Research Institute	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> In progress <input type="radio"/> Other ()

7. Details of Contacts		☞ Choose or fill out any relevant items below	
7.1 Contacts (Do you have any experience of contact with anyone after the onset of symptoms?)	<input type="radio"/> Yes (☞ If yes, please fill in the blanks of Section 7. Details of Contacts) <input type="radio"/> No		
	The number of people you have come into contact with since the onset of symptoms ☞ person(s) in total		
	• Family members, housemates, and cohabitants	person(s)	
	• Those in a hospital/clinic (Name of the hospital/clinic:)	person(s)	
	• Those who stayed in the same space as you while in a vehicle (Vehicle type:)	person(s)	
	• Other ()	person(s)	
* For contacts investigation and relevant details, refer to the Contact and Exposure Investigation Form. * Please refer to the Monkeypox Response Guidelines, with regard to registering contacts on the web system			

8. Final Conclusion		☞ Choose any items or fill in the blanks below
8.1 Case management	<input type="radio"/> Under treatment	

