

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES

Division of Environmental Health & Communicable Disease Prevention

Regions for Statewide Disease Investigation / Terrorism Response



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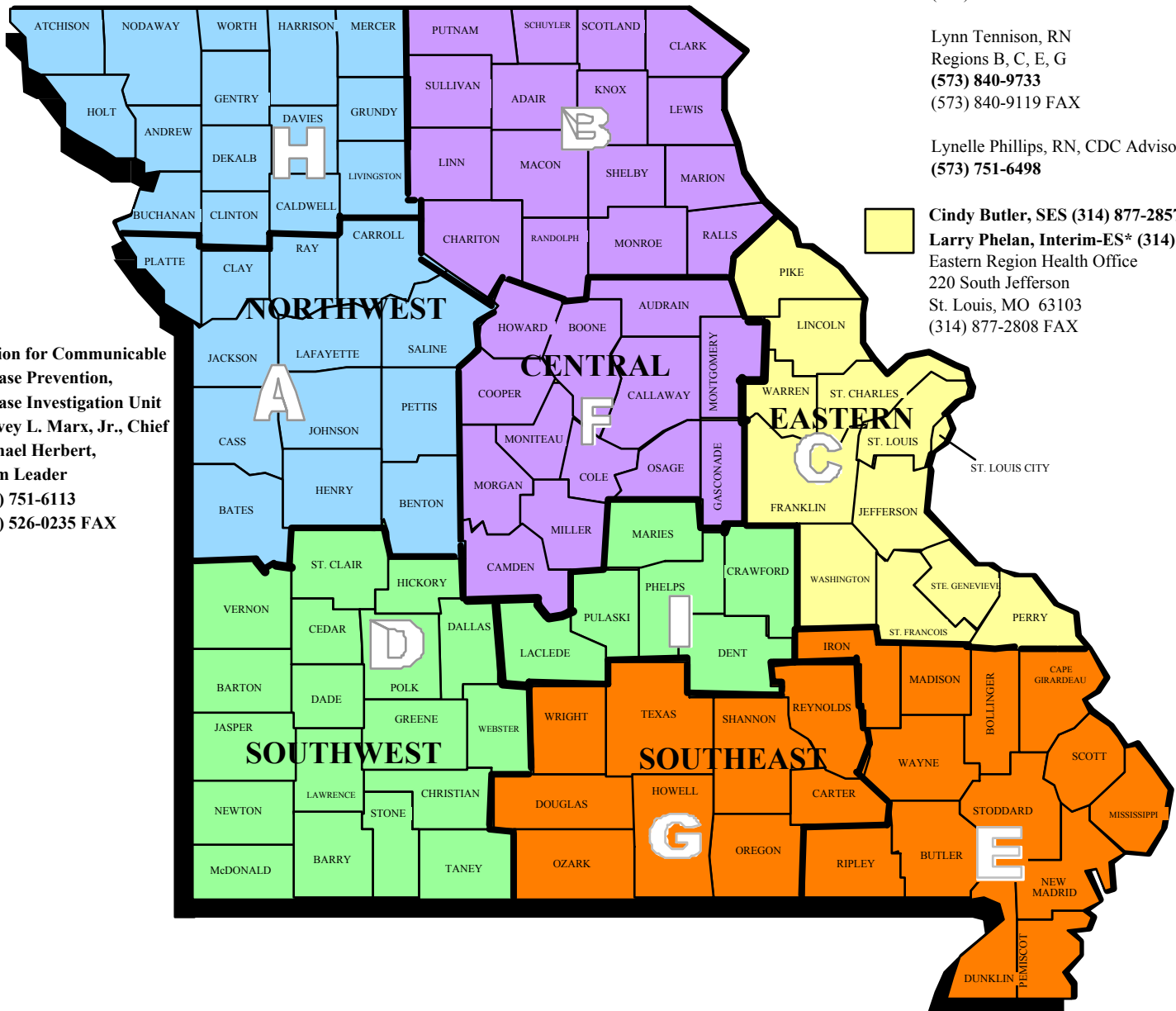
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Figure 3. VAERS Smallpox Follow-up Form

Smallpox Vaccine VAERS Report Follow-up Worksheet

INSTRUCTIONS: To be used for followup of designated VAERS reports. Please request additional medical records, such as hospital discharge summary as appropriate.

Smallpox Vaccination History

Diagnosis and Therapy

1. Has the patient been vaccinated with smallpox vaccine before 2002? *(Please circle answer)*

Never vaccinated Don't Know Vaccinated
If yes, when? In childhood On entry into the military Laboratory worker

2. Has the patient been vaccinated with smallpox vaccine recently (2002-3)? If so, when?

Vaccination date: ___/___/___ Patient Vaccination Number (PVN): _____

3. Do you have a working diagnosis for this patient? YES NO
If yes, what is it? _____

4. Was VIG used? YES NO

5. Was cidofovir used? YES NO

6. PATIENT VACCINATED DESPITE CONTRAINDICATION: N/A APPLICABLE (circle one)

Did patient have any of these conditions at the time of vaccination?

___Pregnancy ___Immunosuppression ___Skin Disease ___Inflammatory Eye Disease

Life-threatening allergic reactions to polymyxin, neomycin, streptomycin, tetracycline at previous smallpox vaccination?
YES NO

If patient vaccinated despite contraindications, please elaborate: _____

CONTACTS: N/A APPLICABLE (circle one):

7. Location of Exposure: ___Home ___Hospital ___Other ___Workplace ___Not known

8. Means of Exposure: ___Known ___Not known

If known, please check:

- ___Direct to skin
- ___Needle stick
- ___Contact with dressing
- ___Handled objects
- ___Health care contact within 3 weeks
- ___Sexual
- ___Nursing mother
- ___Other

9. Is the timing and duration of exposure known? YES NO

If yes, complete: Start date: ___/___/___ Start Time: ___:___AM/PM End Date: ___/___/___ End Time: ___:___AM/PM

10. Contact information of vaccinee to whom patient exposed:

NAME: _____ ADDRESS: _____

TELEPHONE NUMBER: _____

Disposition/outcome: ___Recovered ___Recovered with sequelae (specify) _____ Recovering (specify) _____

___Deceased

VAERS ID: _____ E-report #: _____ Date of followup ___/___/___

Reviewer: _____