

**Houston Methodist Referral for Monkeypox Screening and Testing****Fax to 713-441-4417****HM2586**

<b>PATIENT DEMOGRAPHICS</b>				
LAST NAME	FIRST NAME	MIDDLE INITIAL	DOB	SEX <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS	CITY	STATE	ZIP	
TELEPHONE		EMAIL		
<b>PHYSICIAN INFORMATION</b>				
PHYSICIAN			NPI #	
PHYSICIAN'S SIGNATURE			DATE / TIME	
OFFICE CONTACT NAME & PHONE NUMBER				

**Please note all fields are required; missing data will result in referral denial.****Diagnosis Code (ICD-10):** \_\_\_\_\_**Does the patient have any of the following symptoms? Date of symptoms onset:** \_\_\_\_\_

<input type="checkbox"/> Rash	<input type="checkbox"/> Pruritis (itching)	<input type="checkbox"/> Myalgia (muscle aches)	<input type="checkbox"/> Rectal Bleeding
<input type="checkbox"/> Enlarged Lymph Nodes	<input type="checkbox"/> Vomiting or Nausea	<input type="checkbox"/> Headache	<input type="checkbox"/> Pus or Blood in Stool
<input type="checkbox"/> Cough	<input type="checkbox"/> Chills	<input type="checkbox"/> Tenesmus (urgency to defecate)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eye Lesions	<input type="checkbox"/> Malaise (general feeling of illness/weakness)	<input type="checkbox"/> Rectal Pain	
<input type="checkbox"/> Conjunctivitis			

**Does the patient have fever?**  Yes or  No; If yes, highest temperature \_\_\_\_\_° F**If the patient has a rash when was the onset? Date of rash onset:** \_\_\_\_\_**At what site(s) is the rash currently located?**

<input type="checkbox"/> Face	<input type="checkbox"/> Mouth, Lips, or Oral Mucosa	<input type="checkbox"/> Legs	<input type="checkbox"/> Genitals
<input type="checkbox"/> Head	<input type="checkbox"/> Trunk	<input type="checkbox"/> Palms of Hands	<input type="checkbox"/> Perianal
<input type="checkbox"/> Neck	<input type="checkbox"/> Arms	<input type="checkbox"/> Soles of Feet	<input type="checkbox"/> Other: _____

**Distribution of lesions (mark one):**

Centrifugal (concentrated at the head and extremities)  
 Centripetal (concentrated on the trunk)

**Current lesion development stage(s):**  Macules  Papules  Vesicles  Pustules  Scabs**Are all lesions at the same stage?**  Yes  No  Unknown**Are the lesions deep seated and profound (i.e., are the lesions deep in the skin)?**  Yes  No  Unknown**Are the lesions well-circumscribed (i.e., are the lesions well defined from the surrounding skin)?**  Yes  No  Unknown**Are the lesions umbilicated (i.e., are the centers of the lesions depressed like a navel)?**  Yes  No  Unknown**In the 21 days before symptom onset, did the patient (mark all that apply):**

Have close contact with a known monkeypox case? If Yes, please list date(s): \_\_\_\_\_  
 Have any sexual encounters? If yes,  Any Male(s)  Any Female(s)  Any Non-binary Person(s)

Date(s) of sexual contact: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

