HSE Public Health: National Health Protection Office
FSS Sláinte Poiblí: An Oifig Náisiúnta um Chosaint Sláinte

Interim Guidance for the Public Health Management of Cases and Contacts of mpox in Ireland - **Chapter 4: Contact Tracing Matrix (Clade I and Clade II)**

Please note that this document should be used in tandem with other Interim Management of Mpox documents.

Readers should not rely solely on the information contained within these guidelines. Guidance information is not intended to be a substitute for advice from other relevant sources including, but not limited to, the advice from a health professional. Clinical judgement and discretion will be required in the interpretation and application of this guidance. This guidance is under constant review based upon emerging evidence at national and international levels and national policy decisions.
For further information please contact rgdu@hpsc.ie

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VERSION HISTORY

Version History		
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1.1	02/01/2025	Minor update to internal link within document
1.2	03/03/2025	Update to contact tracing
1.3	07/04/2025	Updated NIAC links & footnotes.
1.4	12/06/2025	Updated due to re-classification of mpox Clade I as no longer being HCID.
1.5	12/11/2025	Inclusion of additional text re: MPOX HCW Risk Assessment Tool

Contents

1.0 Introduction

1.1 Purpose

This guidance provides principles for Public Health Risk Assessment (PHRA), risk mitigation (i.e. appropriate isolation and vaccination advice) and follow-up of contacts of confirmed mpox cases (both Clade I and II which are now managed identically for contact tracing purposes). A dedicated **Mpox Healthcare Risk Assessment Tool** is also available to support healthcare worker (HCW) risk stratification following potential occupational exposure.

Mpox is a viral zoonotic disease that is caused by the MPXV virus. There are 2 distinct clades of MPXV, clade I and clade II. Mpox was previously classified as a high consequence infectious disease (HCID)[1]. In January 2023, the HCID Clinical Advisory Group (CAG) advised that clade II mpox no longer met the criteria for an HCID. In May 2025, the HCID CAG recommended that clade I mpox should no longer be classified as an HCID. This guidance therefore covers the contacts of all cases of mpox, irrespective of clade, and replaces the clade specific contact tracing guidance previously published.

An mpox case is defined as a case that meets the confirmed or highly probable **case definition**.

Health professionals undertaking the risk assessment should take into account the extent of lesions at the time of exposure, as the risk of transmission will be higher if there are widespread uncovered lesions on uncovered areas (for example, hands or face) compared with, for example, a small number of localised genital lesions or if the case was displaying respiratory symptoms at the time of contact, compared to an asymptomatic or pre-symptomatic individual. Contact(s) who are within twenty-one days of exposure to confirmed case of mpox should be advised by the healthcare professional/s to inform any healthcare facility of this exposure when they present for medical assessment/treatment.

[1] **HCID:** High consequence infectious disease (HCID is defined as: an acute infectious disease; typically having a high case-fatality rate; not always having effective prophylaxis or treatment; often difficult to recognise and detect rapidly; able to spread in the community and within healthcare settings; and requiring an enhanced, individual, population, and system response to ensure it is managed effectively, efficiently and safely.

2.0 Contact Tracing

2.1 Rationale

Contact tracing is a key public health measure to control the spread of infectious pathogens such as MPXV. It allows for the interruption of chains of transmission and can also help people at a higher risk of developing severe disease to identify their exposure more quickly, so they can monitor their health status and seek medical care quickly if they become symptomatic. Cases should be interviewed as soon as possible to elicit the names and contact information of all potential contacts and identify events, gatherings, venues or places visited where contact with other people may have occurred. **Contacts of cases should be notified as soon as possible and advised to monitor their health status and seek medical care if they develop symptoms**.

In the current context, as soon as a suspected case is identified, contact identification and contact tracing should be initiated, while further investigation of the source case is ongoing to determine if the case can be classified as probable or confirmed; in the event that a case is classified as denotified (i.e., no longer considered a suspected or probable case), contact tracing may be adapted to the new circumstances (e.g. for contact notification for another sexually transmitted infection if indicated) or stopped if no longer required.

2.2 Definition of a Contact

A contact is defined as a person who has been exposed to a person with suspected (clinically compatible), probable or confirmed mpox during the infectious period (refer to **Section 2.6** has additional information around General Principles for undertaking mpox Public Health Risk Assessment) and who has one or more of the following exposures:

- direct skin-to-skin, skin-to-mucosal or mouth-to-mucosal physical contact (such as touching, hugging, kissing, intimate oral or other sexual contact[2]);
- contact with contaminated materials such as personal belongings, clothing or bedding, including material dislodged from bedding or surfaces during handling of laundry or cleaning of contaminated rooms;
- prolonged face-to-face respiratory exposure in close proximity (inhalation of respiratory droplets and possibly short-range aerosols);
- respiratory (i.e., possible inhalation) or mucosal (e.g., eyes, nose, mouth) exposure to lesion material (e.g., scabs/ crusts) from a person with mpox; and

[2] **Sexual contact** includes sexual intercourse, intimate skin on skin contact, or use of sex toys.

- The above also apply for health workers potentially exposed in the absence of proper use of appropriate personal protective equipment (PPE).

In settings where zoonotic transmission occurs, community contacts for point source exposure may include other persons hunting, selling, preparing or consuming the bushmeat meal at the same time.

2.3 The purpose of contact tracing is to:

- Identify contacts;
- Ensure contacts are aware of:
    - their potential exposure;
    - their potential to develop infection even if fully vaccinated;
    - expectations of monitoring for any signs/symptoms (including the need to monitor for mild symptoms that can go unnoticed);
    - risk mitigation measures to practice for 21 days post-exposure, depending on the circumstances (e.g., ensure contacts are aware of and can evaluate the risks associated with planned activities including sexual activity, travelling or attending social events/ gatherings);
    - the importance of consistently practising recommended public health measures, and
    - what to do if they develop mpox symptoms (e.g., isolate immediately, seek prompt medical assessment)
- Provide information about post-exposure prophylaxis and refer to their healthcare professional to prevent the onset of disease and stop further transmission, if clinically indicated;
- Identify symptomatic contacts (such as, additional cases) as early as possible; and
- Facilitate prompt clinical assessment by a healthcare professional, laboratory diagnostic testing and treatment if signs or symptoms develop.

It is recommended that all individuals who are contacts of a confirmed, probable or suspected case be rapidly identified and assessed by PHRA. Such assessment will determine their exposure risk level and the appropriate public health recommendations to follow.

Recommendations are shown below and apply for the 21-day period following the contact's last exposure to a known probable[3] or confirmed case.

Note: Along with determining exposure risk level, PHRA may further adjust recommendations based on a thorough individual assessment of a contact's specific risk factors. For example, PHRA may consider if the contact:

- has previously received vaccination against smallpox or mpox, and if so, consider the vaccine product, number of vaccines received, and the time since the last vaccine dose
    - For more information on vaccination recommendations based on the individual situation, refer to the **National Immunisation Advisory Committee (NIAC) guidelines**.
- has recovered from a previous mpox infection.
- is at higher risk of severe disease, including individuals who are immunocompromised (e.g., HIV with low CD4 levels), pregnant or young children including infants.
- is resident in a setting which is high risk for transmission and/ or may have higher risk of having immunocompromised individuals, especially congregate migrant settings.

[3] With **proviso that these specific recommendations can be stood down, in the probable case is denotified**, but if another infectious disease is confirmed that appropriate Public Health actions are taken to mitigate for onward transmission.

2.4 Contact Tracing Matrix (MPXV Clade I & II)

Contact Tracing Matrix			
EXPOSURE RISK	**DESCRIPTION**	**EXAMPLE SCENARIOS**	**PUBLIC HEALTH ADVICE**
HIGH Unprotected direct contact or high-risk environmental contact.	Direct exposure of broken skin or mucous membranes to mpox case, their bodily fluids or potentially infectious material (including clothing or bedding) without wearing appropriate PPE. OR Prolonged or frequent exposure to potentially infectious material contaminated by the case (including clothing or bedding) without wearing appropriate PPE. This includes: • inhalation of droplets or dust from cleaning contaminated rooms • mucosal exposure to splashes • penetrating sharps injury from contaminated device or	**Healthcare setting** Bodily fluid in contact with eyes, nose, or mouth. Penetrating sharps injury from used needle. Person in room during aerosol-generating procedure without appropriate respiratory PPE. Changing a patient's bedding or cleaning a contaminated room without appropriate PPE. **Non-healthcare setting** Sexual or intimate contact with or without a condom. Higher risk household contacts who have had close skin to skin contact, for example frequent touching or cuddling, or who have shared bedding, providing care, clothing or towels with the case.	**Passive monitoring** if feasible for signs/symptoms (See Appendix A) and instructions for contacting healthcare facility as required (i.e. GP/OOH Service/Emergency Department). • If symptoms develop – immediately self-isolate, leave work, seek medical review, and abstain from all sexual contact. Practice proper hand hygiene and respiratory etiquette. Do not donate bodily fluids or tissues, including blood and sperm for 21 days from last exposure. Individuals should avoid undertaking any travel, including international travel, until they are determined to no longer constitute a public health risk for others. **Should risk assess for vaccination in line with NIAC recommendations (BN Vaccine (e.g. Imvanex ®) ideally within four days (up to a maximum of 14 days) post exposure.** The most current vaccine guidance can be found **here**.

	through contaminated gloves • people who have shared a residence (shared kitchen and/or bathroom and/or living space) either on a permanent or part time basis with a person who has been diagnosed with mpox and who have spent at least one night in the residence during the period when the case was infectious	Avoid sexual or intimate contact and other activities involving skin to skin contact for 21 days from last exposure. Avoid contact with immunocompromised people, pregnant women, and children aged under 5 years where possible for 21 days from last exposure. Consider exclusion from work or re-deployment if feasible for 21 days on case-by-case basis following a risk assessment, if work involves contact with immunocompromised people, pregnant women, or children under 5 years (not limited to H&CWs). Contacts who are children (i.e. 5 years and over) do not require exclusion from school/childcare facility (CCF). Alert any H&CWs that provide medical care of the potential exposure risk. Avoid attendance to specified high-risk settings like **congregate settings**[4], where possible: • If this is unavoidable, consider wearing a surgical mask in these settings, and allow single room occupancy/ office with dedicated bathroom; or

[4] **Congregate setting(s):** refer to a range of facilities where people (most or all of whom are not related) live or stay overnight and use shared spaces (e.g., common sleeping areas, bathrooms, kitchens) such as: homeless shelters, refuges, group homes and State-provided accommodation for refugees and applicants seeking protection e.g. UCTAT, IPAS. This will also cover prisons, military bases, boarding schools, and detention centres. Those living or staying in the facility are referred to as residents.

			For individuals who are resident in congregate settings, it is advised to consider: • Temporary accommodation/relocation to the **National Infectious Diseases Isolation Facility**, where appropriate and available. • **Active monitoring**[5] of symptoms and potential contacts (See Appendix B), if resources permit, following a public health risk assessment. This may include daily symptom checks, temperature monitoring, and prompt testing if symptoms develop. This is to reduce the risk of spreading infection within the setting.
Medium Unprotected exposure to infectious materials including droplet or airborne potential route.	Intact skin-only contact with an mpox case, their body fluids or potentially infectious material or contaminated fomites (excluding household contacts, as above). OR Passengers seated directly next to a case only where the case had exposed lesion or had respiratory symptoms on a plane (or any other	**Healthcare setting** Clinical examination of patient before diagnosis without appropriate PPE. Entering patient's room without wearing appropriate PPE and within one metre for at least 15 minutes with the case. Subsequent patients in consulting room after an mpox case was seen and prior to room cleaning. Spillage or leakage of laboratory specimen onto intact skin.	**Passive monitoring** if feasible for signs/symptoms (See Appendix A) and instructions for contacting healthcare facility as required (i.e. GP/OOH Service/Emergency Department). • If symptoms develop – immediately self-isolate, leave work, seek medical review, and abstain from all sexual contact. Practice proper hand hygiene and respiratory etiquette. Do not donate bodily fluids or tissues, including blood and sperm for 21 days from last exposure.

[5] Active monitoring should be considered in congregate settings where resources permit, as there is a risk that passive surveillance in a high risk setting with residents either reluctant to or not understanding request to report any emergent symptoms risks disease amplification and overspill into wider community.

	mode of transport where it is known that they have sat next to the case). Specifically, passengers within one metre (i.e. same rows/in front/behind; all within car/van) for at least 15 minutes with an mpox case without wearing appropriate PPE.[6] OR No direct contact but within one metre of a case for at least 15 minutes without wearing appropriate PPE.	**Non-healthcare setting** Lower risk household contact: individuals who live in the same household but do not meet the criteria of HIGH risk. Providing care for case/cared for by a case, or having skin/mucosal contact with case's unwashed bedding, and personal items Sharing a mode of transport with case or sitting within two rows (in all directions) to case on plane[6].	Individuals should avoid undertaking any travel, including international travel, until they are determined to no longer constitute a public health risk for others. Contacts who are children do not require exclusion from school / CCF. **Should risk assess for vaccination in line with NIAC recommendations (BN Vaccine (e.g. Imvanex ®) ideally within four days (up to a maximum of 14 days) post exposure.** The most current vaccine guidance can be found **here**. Avoid sexual or intimate contact and other activities involving skin to skin contact for 21 days from last exposure. Avoid contact with immunocompromised people, pregnant women, and children aged under 5 years where possible for 21 days from last exposure. Consider exclusion from work following a risk assessment for 21 days, especially if work involves contact with immunocompromised people, pregnant women, or children under 5 years (not limited to H&CWs). Risk assessment around redeployment to different area may be considered.

[6] Consideration should be given when undertaking Public Health Risk Assessment (PHRA) for contact tracing for airline contacts. This should include evaluating seating configurations such as 2:2, 3:3, and 3:4:3 patterns, as these can impact the inclusivity of passengers, particularly those who need to be included in contact tracing efforts.

			Alert any H&CWs that provide medical care of the potential exposure. Avoid attendance to specified high-risk settings like **congregate settings**[4], where possible: • If this is unavoidable, consider wearing a surgical mask in these settings, and allow single room occupancy/ office with dedicated bathroom; or For individuals who are resident in congregate settings, it is advised to consider: • Temporary accommodation/relocation to the **National Infectious Diseases Isolation Facility**, where appropriate and available. • **Active monitoring**[5] of symptoms and potential contacts (See Appendix B), if resources permit, following a public health risk assessment. This may include daily symptom checks, temperature monitoring, and prompt testing if symptoms develop. This is to reduce the risk of spreading infection within the setting.
Low Protected physical or droplet exposure. No physical contact, unlikely droplet exposure.	Contact with mpox case or environment contaminated with MPXV while wearing appropriate PPE (with no known breaches), OR	**Healthcare setting** H&CW wearing appropriate PPE. H&CW entering patient room without PPE and: • Without direct contact with patient or their bodily fluids; and	Nil specific beyond: • Practice proper hand hygiene and respiratory etiquette. No restriction of activities. Can continue with routine activities and travel as long as asymptomatic.

	H&CW involved in care of an mpox case not wearing appropriate PPE without direct contact and maintained a distance beyond one metre and no direct contact with contaminated objects or bodily fluids Community contact beyond one metre of an mpox case for at least 15 minutes, OR Passengers sitting beyond one metre from an mpox case on plane. Also consider for passengers on bus, and train.	• Maintaining more than one metre from patient. Person undertaking decontamination of rooms where mpox case(s) stayed, while wearing appropriate PPE. **Non-healthcare setting** Passengers sharing a mode of transport who have been seated more than one metre, but not directly next to a case, where the case did not have exposed lesions. Driver and passengers in shared car or taxi with case where the case did not have exposed lesions.	No post exposure vaccination required.
No identifiable risk No prolonged physical or droplet exposure	Not meeting any of the above criteria.		Nil specific beyond: • Practice proper hand hygiene and respiratory etiquette. No restriction of activities. Can continue with routine activities and travel as long as asymptomatic. No post exposure vaccination required. No monitoring needed – but can provide information around mpox. But this should be risk

	assessed by Department of Public Health – warn and inform can be provided.

2.5 General Principles for undertaking mpox Public Health Risk Assessment

- Transmission requires close physical proximity or interaction with patient, or the patient's intimate belongings (bedsheets, pillowcase, towels, personal toilet belongings, personal utensils).
- Risk increases with length of contact time, and degree of physical proximity.
- Infectiousness begins with onset of symptoms (or if rash is the only symptom, from 24 hours before the onset of rash), and increases with the progressive development of symptoms (coughing/sneezing, rash development with weeping/ de-sloughing).
- The infectious period ends with final de-sloughing of crusted lesion scabs and the appearance of healthy skin beneath (generally 2-3 weeks but can take as long as 4 weeks).
- In healthcare settings, regarding the risk of transmission:
    - The presence of a rash increases the potential for spread - the more extensive, exudative or sloughing the rash, the greater the risk.
    - If patient has respiratory symptoms (e.g. cough, coryza, sneeze) the greater the risk of droplet spread (most likely in those with oropharyngeal lesions/bronchial or pulmonary involvement).
    - Aerosol generating procedures increase the risk of airborne spread.
    - Disseminated environmental skin squames, particularly during changes of bed linen, will also increase the risk.
- Mask-wearing by patient with respiratory symptoms in presence of others, will reduce the potential for spread - even in the absence of respiratory symptoms may reduce the risk of transmission.
- Mpox contacts who have received two documented doses of vaccine (either through PrEP or PEP) no longer need to be considered contacts from fourteen days following their second vaccine dose.
- **Immediate self-isolation following the development of any symptoms is the most effective measure - after vaccination - to contain the spread of mpox**.

Notes for Health & Care Workers

- Certain H&CW occupational contacts (High risk only) may, on the basis of a risk assessment, warrant isolation for 21 days from the date of their last contact, if the level of, or nature of exposure (direct contact of infected patient's tissue/ fluids with

contact's mucosal surfaces etc), or where the severity of the patient's symptoms are considered to significantly increase the risk of disease acquisition.

- If a high-risk H&CW contact following significant exposure, is at greater likelihood of conversion, but does not require isolation, consideration should be given to risk assessing the need to limit contact with known severely immunocompromised patients, children under 5 years of age, and pregnant women.
- A dedicated **Mpox Healthcare Risk Assessment Tool** is also available to support healthcare worker (HCW) risk stratification following potential occupational exposure. This tool aligns with both national guidance and the WHO HCW exposure assessment framework. It is designed to assist IPC teams, occupational health, and public health professionals in evaluating exposure scenarios and guiding appropriate follow-up actions. The tool incorporates the risk assessment matrix set out in this chapter and WHO methodology to ensure a consistent and practical approach to exposure management.

Appendix A

PASSIVE MONITORING TEMPLATE EMAIL/LETTER

NAME	
DATE of BIRTH	
ADDRESS	
EIRCODE	
CONTACT NUMBER	
CONTACT EMAIL	
GP DETAILS	Permission provided to contact GP, if needed: YES ☐ NO ☐ Not Asked ☐
DATE of MPOX EXPOSURE	
DATE of LAST DAY of ACTIVE MONITORING	

Dear [*INSERT NAME*]

You have been identified as a close contact of a case of mpox. **You have been placed under passive monitoring by the Medical Officer of Health for 21 days since your contact with a confirmed case of mpox**. Passive monitoring means that you should monitor yourself and how you are feeling, and if you develop any symptoms, you should immediately self-isolate, leave work, seek medical review (i.e. GP, Out of Hours Services, Emergency Room, Sexual Health Services) and abstain from all sexual contact.

Being under passive monitoring can feel intrusive. However, to ensure you do not pass any infection on to others, it is extremely important that you:

- Follow the directions for passive monitoring, for 21 days.
- Ensure you wash your hands frequently and practice respiratory etiquette, and information can be found here.
- Abstain from sexual contact for the period of your monitoring.

You should avoid undertaking any travel, including international travel, until they are determined to no longer constitute a public health risk for others.

You can attend work/school as usual and undertake normal social activities. However, it is important that for the 21 days following your contact with the case, you monitor yourself for the early symptoms of mpox. If you work/attend school that involves, contact with immunocompromised people, pregnant women, or children under 5 years (not limited to H&CWs). Risk assessment around redeployment to different area may be considered, so you might need to link with Line Manager, if this is required.

Please use this form to record your temperature twice daily (when you get up in the morning and during the evening before you go to bed) using a digital thermometer, and

to record any symptoms you develop during this period. You can return your completed form to your regional Department of Public Health.

Regularly check if you have a fever (a high temperature) using a thermometer, if you have one. Signs that you have a high temperature include your chest or back feeling hotter than usual, or other symptoms such as shivering (chills), sweating, or warm, red skin (this may be harder to see on black or brown skin). Follow the manufacturer's instructions on use. Leave at least 20 minutes between taking exercise or consuming warm or cold drinks or food and checking your temperature. **If you develop symptoms, you should exclude yourself from work, self-isolate and call your GP/health provider immediately. You should also abstain from any sexual contact. Whenever you call your GP/health provider make sure to tell them you are a mpox contact.**

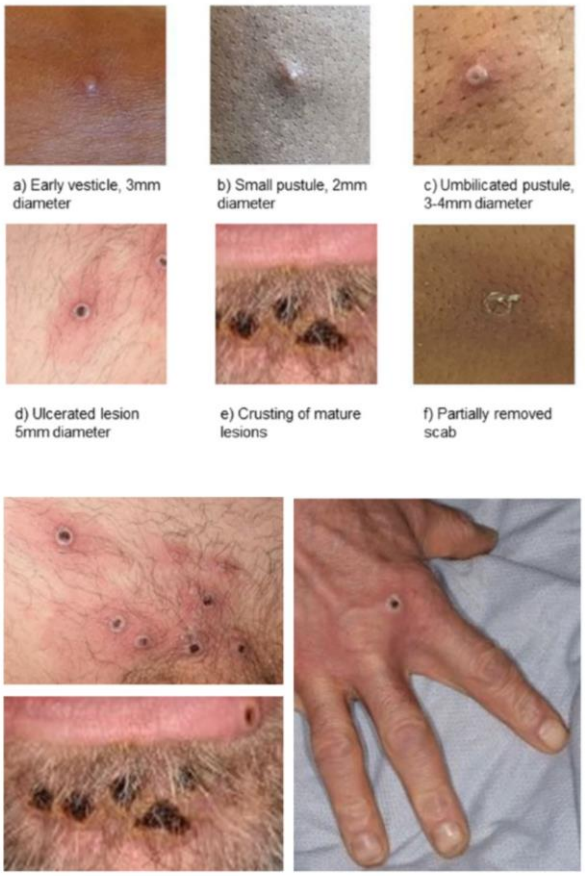
In case of an emergency call 112/999 and advise them that you have had contact with a case of mpox.

The symptoms of mpox are:

- Rash that may be painful or itchy (may look like pimples or blisters to start);
- Fever (temperature at or above 38.5°C);
- Chills;
- Swollen lymph nodes;
- Exhaustion;
- Muscle aches and backache; and
- Headache.

People may experience all or only a few symptoms. Others only experience a rash.

Images of mpox lesions



You can visit these websites for fact-based information about mpox:

- HSE website: **https://www2.hse.ie/conditions/mpox/**
- HPSC website: **https://www.hpsc.ie/a-z/zoonotic/monkeypox/**

If you have any questions, feel free to contact you regional Department of Public Health.

Yours sincerely,

[***NAME, TITLE, and CONTACT INFORMATION***]

Daily Log for Contact (to be completed by contact and returned to regional Department of Public Health)

NAME	
DATE of BIRTH	
ADDRESS	
EIRCODE	
CONTACT NUMBER	
CONTACT EMAIL	
GP DETAILS	Permission provided to contact GP, if needed: YES ☐ NO ☐ Not Asked ☐
DATE of MPOX EXPOSURE	
DATE of LAST DAY of ACTIVE MONITORING	

Day	Date dd/mm/yyyy	AM – Temperature	PM – Temperature	Other Symptoms[7] (Y/N) (Describe)
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
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19				
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21				

[7] **If you develop any symptoms**, you should immediately self-isolate, leave work, seek medical review (e.g. GP, Out of Hours Services, Emergency Room, Sexual Health Services) and abstain from all sexual contact.

Appendix B

ACTIVE MONITORING TEMPLATE EMAIL/LETTER

NAME	
DATE of BIRTH	
ADDRESS	
EIRCODE	
CONTACT NUMBER	
CONTACT EMAIL	
GP DETAILS	Permission provided to contact GP, if needed: YES ☐ NO ☐ Not Asked ☐
DATE of MPOX EXPOSURE	
DATE of LAST DAY of ACTIVE MONITORING	

Dear [*INSERT NAME*]

You have been identified as a close contact of a case of mpox. **You have been placed under active monitoring by the Medical Officer of Health for 21 days since your contact with a confirmed case of mpox**. Active monitoring means that you should monitor yourself and how you are feeling, and if you develop any symptoms, you should immediately self-isolate, leave work, seek medical review (i.e. GP, Out of Hours Services, Emergency Room, Sexual Health Services) and abstain from all sexual contact.

Being under active monitoring can feel intrusive. However, to ensure you do not pass any infection on to others, it is extremely important that you:

- Follow the directions for active monitoring, for 21 days.
- Ensure you wash your hands frequently and practice respiratory etiquette, and information can be found **here**.
- Abstain from sexual contact for the period of your monitoring.

You should avoid undertaking any travel, including international travel, until you are determined to no longer constitute a public health risk for others.

You can attend work/school as usual and undertake normal social activities. However, it is important that for the 21 days following your contact with the case, you monitor yourself for the early symptoms of mpox. If you work/attend school that involves, contact with immunocompromised people, pregnant women, or children under 5 years (not limited to H&CWs). Risk assessment around redeployment to different area may be considered, so you might need to link with Line Manager, if this is required.

Please use this form to record your temperature twice daily (when you get up in the morning and during the evening before you go to bed) using a digital thermometer, and

to record any symptoms you develop during this period. You will receive a daily call from your regional Department of Public Health to ascertain how your active monitoring is progressing.

If you feel unwell at any time, please take your temperature. Make sure to take your temperature in your mouth (and not under your arm). Follow the manufacturer's instructions on use. Leave at least 20 minutes between taking exercise or consuming warm or cold drinks or food and checking your temperature. If you feel unwell in any way, please check your temperature. **If you develop symptoms, you should exclude yourself from work, self-isolate and call your GP/health provider immediately. You should also abstain from any sexual contact. Whenever you call your GP/health provider make sure to tell them you are a mpox contact.**

If you develop a fever or any of the symptoms below, you should call your GP/health provider. If you are feeling very unwell then you should seek medical attention.

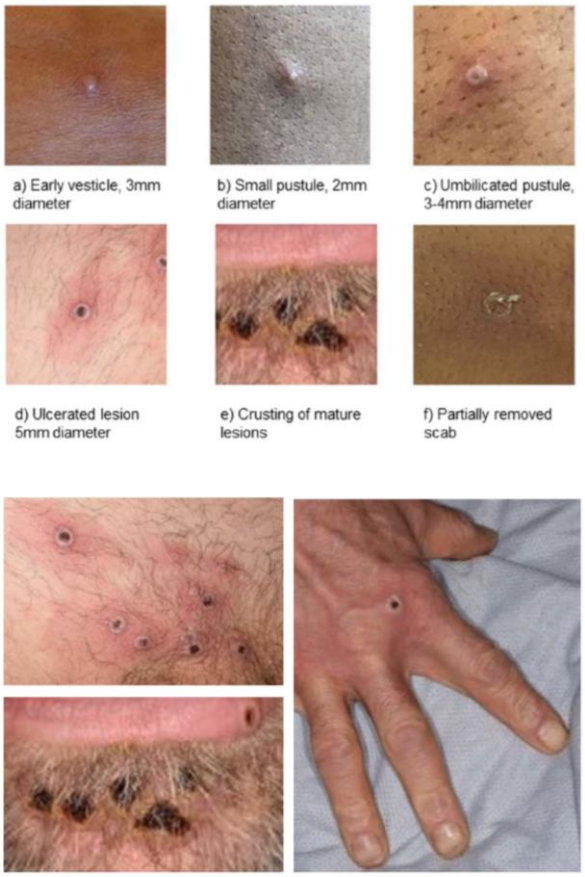
In case of an emergency call 112/999 and advise them that you have had contact with a case of mpox.

The symptoms of mpox are:

- Rash that may be painful or itchy (may look like pimples or blisters to start);
- Fever (temperature at or above 38.5°C);
- Chills;
- Swollen lymph nodes;
- Exhaustion;
- Muscle aches and backache; and
- Headache.

People may experience all or only a few symptoms. Others only experience a rash.

Images of mpox lesions



You can visit these websites for fact-based information about mpox:

- HSE website: **https://www2.hse.ie/conditions/mpox/**
- HPSC website: **https://www.hpsc.ie/a-z/zoonotic/monkeypox/**

If you have any questions, feel free to contact you regional Department of Public Health.

Yours sincerely,

[***NAME, TITLE, and CONTACT INFORMATION***]

Daily Log for Contact (to be completed by Department of Public Health)

NAME	
DATE of BIRTH	
ADDRESS	
EIRCODE	
CONTACT NUMBER	
CONTACT EMAIL	
GP DETAILS	Permission provided to contact GP, if needed: YES ☐ NO ☐ Not Asked ☐
DATE of MPOX EXPOSURE	
DATE of LAST DAY of ACTIVE MONITORING	

Day	Date dd/mm/yyyy	AM – Temperature	PM – Temperature	Other Symptoms[8] (Y/N) (Describe)
1				
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5				
6				
7				
8				
9				
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[8] **If you develop any symptoms**, you should immediately self-isolate, leave work, seek medical review (i.e. GP, Out of Hours Services, Emergency Room, Sexual Health Services) and abstain from all sexual contact.

Appendix C

PUBLIC HEALTH MONITORING TEMPLATE

1. Summary Contact Details

CONTACT NAME: _____ **DoB:** _____

CONTACT ID: [ ] **HSE-Area**: [ ] **County**: [ ]

RHA: [ ]

Healthcare Worker: Y ☐ N ☐ **Contact Phone**: [ ]

Date case identified: ____/____/____

Type of Monitoring:

Passive: ☐

Active[9]: ☐

Exposure Risk:

High Risk: ☐

Medium Risk: ☐

Low Risk: ☐

Date/Time Monitoring began: ____/____/_____ ____:__

Vaccinated: Y ☐ N ☐ Vaccine Brand: _____

Route: subcutaneous ☐ intradermal ☐

Date vaccinated: Dose 1 __/__/__ Dose 2: __/__/_

[9] In only a very small proportion of cases will **active monitoring** (surveillance) may be required. It should be considered if there are concerns about the contact's ability or willingness to complete passive monitoring (e.g., cognitive impairment or transient population). It should also be considered in congregate settings where resources permit, as there is a risk that passive surveillance in a high risk setting with residents either reluctant to or not understanding request to report any emergent symptoms risks disease amplification and overspill into wider community.

2. Summary Case Details

Name: _____ _____

CASE CIDR ID: _____

DoB: _____

Nationality: _____ **Country of Exposure**: _____

Current location: _____

3. Full Contact Details

Name: _____

Address: _____

_____

County: _____ **RHA:** _____ **Eircode:** _____

Phone: _____ **DoB:** ____/____/____

Nationality: _____ **Country of birth:** _____

Sex: Male ☐ Female ☐ Trans male ☐ Trans female ☐Non-binary ☐Unk ☐

HCW: Y ☐ N ☐ **DOB:** ___/___/_____ **Age:** _____

Occupation: _____

GP Name: _____ **GP Phone**:

_

Seen by GP? Y ☐ N ☐ Unk ☐ **Date/Time:** ____/____/_____

Significant past medical history (including mpox infection): _____

_____

Pregnant: Y ☐ N ☐ Unk ☐ **Immunocompromised**: Y ☐ N ☐

Did they previously receive the smallpox vaccine? Y ☐ N ☐

If yes, year of vaccination: _____

Smallpox vaccination (scar): Y ☐ N ☐ Unk ☐

Has the contact been referred for vaccination?

Referred for vaccination ☐Declined ☐Already vaccinated ☐Not offered – outside 14-day window ☐Not offered as per risk matrix ☐Not offered – other☐

If not, why?_____

Vaccinated with Imvanex? Y ☐ N ☐ Date: ____/____/___ Batch No**:** _____

(If no, give reason) _____

Info for Vaccine Referral Form

PPSN: _____

Next of kin name: _____

Next of kin contact number (mobile): _____

Please indicate if referral is recommending a 2nd dose: Y ☐ N ☐ Unk ☐

Referrer name: _____

Referrer contact number: _____

GP Practice Name: _____

Nature of Contact:	**Type of Contact:**
• Household: Y ☐ N ☐ • Sexual: Y ☐ N ☐ • Healthcare: Y ☐ N ☐ • Workplace (non-HC) : Y ☐ N ☐ • Community: Y ☐ N ☐ • Other: Y ☐ N ☐ (*If Other, please specify*	• Indirect: ☐ • Direct: ☐ For episodes of Direct Contact, specify extent/nature of contact/sexual/PPE breach:
Date of last Contact: ___/_____/___	**Ongoing exposure:** Y ☐ N ☐
Exposure Risk: High: ☐ Medium: ☐ Low: ☐	

5. Daily Symptom Check[10]

Is the case currently symptomatic: Y ☐ N ☐

SYMPTOMS	RESPONSE	DATE & TIME of ONSET
Fever	Yes ☐ No ☐ Unknown ☐	
Chills	Yes ☐ No ☐ Unknown ☐	
Headache	Yes ☐ No ☐ Unknown ☐	
Exhaustion	Yes ☐ No ☐ Unknown ☐	
Swollen glands	Yes ☐ No ☐ Unknown ☐	
Cough/sore throat	Yes ☐ No ☐ Unknown ☐	
Backache	Yes ☐ No ☐ Unknown ☐	
Muscle ache	Yes ☐ No ☐ Unknown ☐	
Rash	Yes ☐ No ☐ Unknown ☐	
• Macules • Papules • Vesicles • Pustules • Umbilicated • Scabs	• Yes ☐ No ☐ Unknown ☐ • Yes ☐ No ☐ Unknown ☐ • Yes ☐ No ☐ Unknown ☐ • Yes ☐ No ☐ Unknown ☐ • Yes ☐ No ☐ Unknown ☐ • Yes ☐ No ☐ Unknown ☐	

[10] These are for use if the contact develops symptoms and is for assessment as a probable case – complete only if symptoms develop. Check any symptoms against the **Case Definition**.

Anogenital/orolabial lesions	Yes ☐ No ☐ Unknown ☐
• Describe lesions	

6. Escalation

Date & Time of escalation: _____

Basis for escalation: _____

_____

Referred to: _____

Action Taken: _____

_____

Admitted: YES ☐ NO ☐ UNKNOWN ☐

Name of Facility: _____

Date & Time of admission: _____

7. Exit from Monitoring

Date & Time of exiting: _____