

**Ministry of Health**

Office of Chief Medical  
Officer of Health, Public  
Health

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**Ministère de la Santé**

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May 20, 2022

**SECTION 77.6 HEALTH PROTECTION AND PROMOTION ACT**

**CHIEF MEDICAL OFFICER OF HEALTH ORDER**

**(Order to physicians and registered nurses in the extended class, including Medical Officers of Health, persons who operate a group practice that includes physicians and/or registered nurses in the extended class and to hospitals within the meaning of the *Public Hospitals Act* and regulated health professionals who practice within hospitals to provide information relating to monkeypox virus)**

**ONTARIO MINISTRY OF HEALTH**

**ORDER OF THE CHIEF MEDICAL OFFICER OF HEALTH UNDER SECTION 77.6 OF  
THE HEALTH PROTECTION AND PROMOTION ACT,**

**R.S.O. 1990, c. H.2 (the "Act")**

**WHEREAS** under section 77.6 of the Act, the Chief Medical Officer of Health, where he is of the opinion that there exists an immediate and serious risk to the health of persons anywhere in Ontario, may issue an order directing any health information custodian, as defined in the *Personal Health Information Protection Act, 2004* to provide to the Chief Medical Officer of Health or his or her delegate any information provided for in the order;

**AND WHEREAS**, under section 77.6(2), the Chief Medical Officer of Health is of the opinion, based on reasonable and probable grounds, that the information is necessary to investigate, eliminate or reduce the immediate and serious risk to the health of persons in Ontario presented by monkeypox virus;

**AND WHEREAS**, under section 77.6(3), the information requested in this order is to be used or disclosed only to investigate, eliminate, or reduce the risk and for no other purpose;

**AND WHEREAS**, under section 77.6(1), the Chief Medical Officer of Health may require health information custodians named in the order to disclose information, including personal health information, to a delegate;

**AND HAVING REGARD TO** monkeypox virus being observed nationally and internationally as follows: Since May 2022, there have been, as of the date of this order, over 100 cases of monkeypox virus reported in numerous countries, including countries in Europe, Canada, the USA, and Australia. It is not clear how individuals were exposed, and no source infection has been confirmed, but active investigation continues. Monkeypox virus is endemic in certain parts of Central and West Africa and previous reports of sporadic cases in non-endemic countries were linked to international travel to endemic countries.

**AND HAVING REGARD TO** some cases in Canada presenting to primary care and/or sexual health clinics with unusual rashes or lesions in the mouth or genital area. On May 20, 2022, two people in Quebec were confirmed with monkeypox virus and a confirmed case in the United States with travel history to Quebec was also confirmed for monkeypox virus.

**AND WHEREAS** this order is issued to physicians and registered nurses in the extended class, including Medical Officers of Health, to persons who operate a group practice that includes physicians and/or registered nurses in the extended class and to hospitals within the meaning of the Public Hospitals Act and regulated health professionals who practice within hospitals ("Required Persons").

**THE CHIEF MEDICAL OFFICER OF HEALTH THEREFORE ORDERS** pursuant to the provisions of section 77.6 of the Act that:

1. Every Required Person must provide to the Chief Medical Officer of Health's delegate, the Ontario Agency for Health Protection and Promotion ("Public Health Ontario"), the information outlined in Appendix B ("Case Report Form") respecting any cases of monkeypox virus who meet the case definitions in Appendix A (the "Information").
2. Every Required Person must disclose the Information to Public Health Ontario within one (1) business day after the Required Person learns that it has a patient who meets the case definitions in Appendix A.

3. If a Required Person has a patient that meets the case definitions in Appendix A, the Required Person must complete the Ontario Monkeypox Investigation Tool in Appendix B and send the Information via secure fax to Public Health Ontario **(647- 260-7603)**.
4. Public Health Ontario, as my delegate, shall disclose the Information to the Medical Officer of Health in the respective Public Health Unit where the case or contact resides.
5. The Medical Officer of Health who receives the Information in paragraph 4 shall use the Information for the purposes of investigating, eliminating or reducing the risk to the health of persons created by monkeypox virus, including conducting case and contact management.
6. This Order takes effect immediately and shall remain in force until revoked.

Dated at Toronto this 20th day of May, 2022



Dr. Kieran Moore  
Chief Medical Officer of Health

For more information on monkeypox virus and communications released by the Office of the Chief Medical Officer of Health, please visit:

<https://www.health.gov.on.ca/en/pro/programs/emb/monkeypox.aspx>

Please refer to PHO's website for more testing information at: [Monkeypox Virus | Public Health Ontario](#)

## APPENDIX A

### Confirmed Case

- Laboratory confirmation of infection:
- Detection of monkeypox virus DNA by polymerase chain reaction (PCR) from an appropriate clinical specimen, **OR**
- Isolation of monkeypox virus in culture from an appropriate clinical specimen

### Probable Case

- A new onset rash in keeping with monkeypox illness<sup>1</sup>, **AND**
- At least one (1) other acute sign or symptom of monkeypox illness<sup>2</sup>, **AND**
- Meets at least one (1) of the following epidemiological criteria within 21 days of their symptom onset:
  - High-risk exposure<sup>3</sup> to a probable or confirmed human case of monkeypox, **OR**
  - A history of travel to a region that has reported confirmed cases of monkeypox, **OR**
  - A relevant zoonotic exposure

### Suspect Case

- A new onset rash in keeping with monkeypox illness<sup>1</sup> **AND**
- At least one (1) other acute sign or symptom of monkeypox illness<sup>2</sup>, **AND**
- An alternative diagnosis cannot fully explain the illness.

### Footnotes

<sup>1</sup>Monkeypox illness includes a progressively developing rash that usually starts on the face and then spreads elsewhere on the body. The rash can affect the mucous membranes in the mouth, tongue, and genitalia. The rash can also affect the palms of hands and soles of the feet. The rash can last for 2–4 weeks and progresses through the following stages before falling off: macules, papules, vesicles, pustules, and scabs. There are case reports from North America of an atypical monkeypox virus rash that includes painful genital/oral lesion.

<sup>2</sup>Other monkeypox illness signs or symptoms include fever, lymphadenopathy, chills and/or sweats, headache, back pain/ache, sore throat and/or cough, coryza (inflammation of the mucous membrane of the nose), malaise/listlessness, prostration/distress

<sup>3</sup>High risk exposure includes living in the same household, having direct physical contact including sexual contact, and direct contact with a skin lesion or bodily fluid without appropriate personal protective equipment

## APPENDIX B

# Ontario Monkeypox Investigation Tool

<b>Legend</b>	for interview with case	◆ System-Mandatory	◆ Required	⊘ Personal Health information
*** Note to clinician: Please complete relevant information on <u>pages 1-4</u> before sending to PHO. The responsible public health unit will be responsible for completing the remaining sections***				

## Cover Sheet

⊘ ◆ Client Name: \_\_\_\_\_ Enter name

Alias: \_\_\_\_\_ Enter alias

⊘ ◆ Gender: Select an option

⊘ ◆ DOB: \_\_\_\_\_ YYYY-MM-DD

⊘ Address: \_\_\_\_\_ Enter address

\_\_\_\_\_ Enter address

⊘ Tel. 1: \_\_\_\_\_ ###-###-####

Type:  Home  Mobile  Work  Other, specify

⊘ Tel. 2: \_\_\_\_\_ ###-###-####

Type:  Home  Mobile  Work  Other, specify

⊘ Email 1: \_\_\_\_\_ Enter email address

⊘ Email 2: \_\_\_\_\_ Enter email address

Is the client homeless?  Yes  No

⊘ New Address: \_\_\_\_\_ Enter address

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◆ Language: \_\_\_\_\_ Specify

Translation required?  Yes  No

Proxy respondent

⊘ Name: \_\_\_\_\_ Enter name

Parent/Guardian  Spouse/Partner

Other \_\_\_\_\_ Specify

◆ Physician's Name: \_\_\_\_\_ Enter name

◆ Role:  Attending Physician  Family Physician  
 Specialist  Walk-In Physician  
 Other  Unknown

OPTIONAL

Additional Physician's Name: \_\_\_\_\_ Enter name

Address: \_\_\_\_\_ Enter address

Tel: \_\_\_\_\_ ###-###-#### Fax: \_\_\_\_\_ ###-###-####

Role: \_\_\_\_\_ Enter role

◆ **Symptoms**

*Incubation period can range from 5-21 days, usually 6-13 days.*

*Communicability: most commonly from onset of initial lesions (typically on the tongue and in the mouth), until lesions have crusted. Some cases may be contagious during their early set of symptoms (prodrome) such as fever, malaise, headache before the rash develops.*

Specimen collection date: YYYY-MM-DD

Specimen collection site:

◆ Symptom <i>Ensure that symptoms in bold font are asked</i>	◆ Response					◆ Use as Onset <i>(choose one)</i>	◆ Onset Date YYYY-MM-DD	Onset Time 24-HR Clock HH:MM <i>(discretionary)</i>	◆ Recovery Date YYYY-MM-DD <i>(one date is sufficient)</i>
	Yes	No	Don't Know	Not Asked	Refused				
Fever	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Headache	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Myalgia (muscle aches)	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Fatigue/ Exhaustion	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Swollen lymph nodes (Lymphadenopathy)	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					

Specify location of swollen lymph nodes, if applicable:

Chills	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Rash	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Macular rash	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Papular rash	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Vesicular rash	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					
Pustular rash	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD					

If responding yes to a rash:	Specify location of rash/lesions on the body and whether these are in the same stage of development, if applicable.								
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD
Back pain/ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD
Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD
Oral lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD
Genital lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD
Other, <i>specify</i> (e.g., scabs, other lesions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	YYYY-MM-DD	HH:MM	YYYY-MM-DD

*Note: This list is not comprehensive. There are additional symptoms listed in iPHIS.*

<b>◆ Complications</b>
<input type="checkbox"/> Secondary infection <input type="checkbox"/> Bronchopneumonia <input type="checkbox"/> Sepsis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Corneal infection <input type="checkbox"/> None <input type="checkbox"/> Other <input type="checkbox"/> Unknown
<b>Incubation Period</b>
<i>Enter onset date and time, using this as day 0, then count back to determine the incubation period.</i>
<p style="text-align: center;"> <span style="margin-right: 150px;">- 21 days Select a date</span> <span style="margin-right: 150px;">- 5 day Select a date</span> <span>onset Select a date &amp; time</span> </p>

Medical Risk Factors	◆ Response				Details <i>iPHIS character limit: 50.</i>
	Yes	No	Unknown	Not asked	
Maternal infection (e.g. infant exposed to symptomatic mother during pregnancy or during/after birth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify

Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever received smallpox vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify number of vaccine doses and date of last vaccination If yes, specify if vaccination scar present
Have you ever received chickenpox vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify number of vaccine doses and date of last vaccination If yes, specify if vaccination scar present
❖ Immunocompromised (e.g., by medication or by disease such as cancer, diabetes, untreated HIV etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
❖ Unknown	<input type="checkbox"/>	<input type="checkbox"/>	→ For iPHIS data entry – check Yes for Unknown if all other Medical Risk Factors are No or Unknown.		

<b>Hospitalization &amp; Treatment</b>		<i>Mandatory in iPHIS only if admitted to hospital</i>	
Did you go to an emergency room?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name of hospital: Enter name Date(s): YYYY-MM-DD	
❖ Were you admitted to hospital as a result of your illness (not including stay in the emergency room)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't recall	If yes, Name of hospital: Enter name ❖ Date of admission: YYYY-MM-DD ❖ Date of discharge: YYYY-MM-DD <input type="checkbox"/> Unknown discharge date	
→ For iPHIS data entry – if the case is hospitalized enter information under Interventions.			
Were you prescribed antibiotics or medication for your illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't recall	If yes, Medication: Enter name Start date: YYYY-MM-DD      End date: YYYY-MM-DD Route of administration: Enter route      Dosage: Enter dosage	
Did you take over-the-counter medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't recall	If yes, specify	
Treatment information can be entered in iPHIS under Cases > Case > Rx/Treatments>Treatment as per current iPHIS User Guide			



Call Log Details						
	Date	Start Time	Type of Call	Call To/From	Outcome (contact made, v/m, text, email, no answer, etc.)	Investigator's initials
Call 1	YYYY-MM-DD		<input type="checkbox"/> Outgoing <input type="checkbox"/> Incoming			
Call 2	YYYY-MM-DD		<input type="checkbox"/> Outgoing <input type="checkbox"/> Incoming			
Call 3	YYYY-MM-DD		<input type="checkbox"/> Outgoing <input type="checkbox"/> Incoming			
Call 4	YYYY-MM-DD		<input type="checkbox"/> Outgoing <input type="checkbox"/> Incoming			
Call 5	YYYY-MM-DD		<input type="checkbox"/> Outgoing <input type="checkbox"/> Incoming			
Date letter sent: YYYY-MM-DD						

Case Details			
Aetiologic Agent	Monkeypox virus		
◆ Classification	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Does Not Meet Definition <input type="checkbox"/> Epi-linked	◆ Classification Date	YYYY-MM-DD
◆ Outbreak Case Classification	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Does Not Meet Definition	◆ Outbreak Classification Date	YYYY-MM-DD
◆ Disposition	<input type="checkbox"/> Complete <input type="checkbox"/> Closed- Duplicate-Do Not Use <input type="checkbox"/> Entered In Error <input type="checkbox"/> Lost to Follow Up <input type="checkbox"/> Does Not Meet Definition <input type="checkbox"/> Untraceable	◆ Disposition Date	YYYY-MM-DD
◆ Status	<input type="checkbox"/> Closed Initial here	◆ Status Date	YYYY-MM-DD
	<input type="checkbox"/> Open (re-opened) Initial here	◆ Status Date	YYYY-MM-DD
	<input type="checkbox"/> Closed Initial here	◆ Status Date	YYYY-MM-DD

Behavioural Social Risk Factors in the 5-21 days prior to onset of illness	❖ Response				Details (e.g., Location visited, flight details) <i>iPHIS character limit: 50.</i>
	Yes	No	Unknown	Not asked	
Travel					
❖ Travel within the province in the 5-21 days prior to illness (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	From: YYYY-MM-DD To: YYYY-MM-DD Where: Specify
❖ Travel outside the province in the 5-21 days prior to illness (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Within Canada</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	From: YYYY-MM-DD To: YYYY-MM-DD Where: Specify
<u>Outside of Canada</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	From: YYYY-MM-DD To: YYYY-MM-DD Where: Specify Hotel/Resort: Specify
<b>Attention! If the case travelled during the incubation period and while symptomatic, obtain additional details including flight carrier, dates of travel, whether a mask/respirator was worn in flight and whether lesions were covered during the flight (if applicable).</b>					
❖ Travelled to or lived in a country with endemic or known monkeypox activity in the last <u>21 days</u> (specify province/country)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	From: YYYY-MM-DD To: YYYY-MM-DD Where: Specify
Direct contact (e.g. touch) with a domesticated or wild animals (e.g., rodents, monkeys, squirrels)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Consumption of bush meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
❖ Contact with a symptomatic case of monkeypox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify
Full PPE worn for all interactions with the case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify
Contact with non-intact skin/lesions of a symptomatic case	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify
<b>❖ Create Exposures Identify Exposures to be entered in iPHIS.</b> → For iPHIS data entry – record details of exposure(s) in iPHIS Case Exposure Form as required.					

High Risk Occupation/High Risk Environment		
Are you in a high risk occupation or high risk environment (including paid and unpaid/volunteer position)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Flight attendant <input type="checkbox"/> Health care provider <input type="checkbox"/> Laboratory worker <input type="checkbox"/> Animal handler/keeper <input type="checkbox"/> Other (specify) Occupation: Specify
Name of Employer / Self-employed	Enter name	
Employer Contact Information (name, phone number, etc.)	Enter contact information	
Address	Enter address	
Symptomatic cases are to isolate for 21 days following symptom onset.		

Contact Information			
Are you aware of anyone who experienced similar symptoms before, during, or after you (or your child) became ill? This includes those in your family, household, child care or kindergarten class, sexual partner(s), friends or coworkers.			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Contact 1			
 Name	Enter name	Relation to case	Specify
 Contact information (phone, address, email)	Enter contact information		
Notes	Enter notes		
Recommend contact seek medical attention/testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

Contact 2			
 Name	Enter name	Relation to case	Specify
 Contact information (phone, address, email)	Enter contact information		
Notes	Enter notes		
Recommend contact seek medical attention/testing?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	

Education/Counselling		<i>Discuss the relevant sections with case</i>
Person to person transmission	<input type="checkbox"/> Close contact with respiratory secretions, and skin lesions of an infected person increase the risk of transmission. <input type="checkbox"/> Review importance of personal hygiene.	
Travel-related illness	<input type="checkbox"/> Avoid contact with sick or dead animals while visiting endemic countries. Thoroughly cook all meat, including bush meat.	

Outcome	<i>Mandatory in iPHIS only if Outcome is Fatal</i>
<input type="checkbox"/> Unknown <input type="checkbox"/>  Fatal <input type="checkbox"/> Ill <input type="checkbox"/> Pending <input type="checkbox"/> Residual effects <input type="checkbox"/> Recovered	
<i>If fatal, please complete additional required fields in iPHIS</i>	

**Thank you**

Thank you for your time. This information will be used to help prevent future illnesses caused by Monkeypox. Please note that another investigator may contact you again to ask additional questions if it is identified that there is a possibility that you are included in an outbreak.

**\*\*\*Please fax completed questionnaires to Public Health Ontario at 647-260-7603\*\*\***

V Intervention Type	Intervention implemented (check all that apply)	Investigator's initials	◆ Start Date YYYY-MM-DD	◆ End Date YYYY-MM-DD
Counselling	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
Education (e.g., provided with fact sheet)	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
ER visit	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
Exclusion	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
Hospitalization	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
Letter - Client	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
Letter - Physician	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
Other (i.e., contacts assessed, PHI/PHN contact information)	<input type="checkbox"/>		YYYY-MM-DD	YYYY-MM-DD
<i>→ For iPHIS data entry – enter information under Cases &gt; Case &gt; Interventions.</i>				

<b>Progress Notes</b>
<p style="color: #ccc; margin: 0;">Enter notes</p>