

SHOC Resource Form for Monkeypox Vaccine, Antiviral, and Testing Supplies		Requesting Agency Contact Information	
Date:	Time:	Event: 2022 MPX	
Requestor's Name:		Title:	
Requestor's Organization:			
Phone #:	Mobile #:	Fax #:	
Email Address:			
Patient Risk Level/Exposure			
Patient Risk Level: High <input type="checkbox"/> Intermediate <input type="checkbox"/> Low <input type="checkbox"/>		DE OIDE (Office of Infectious Disease Epidemiology) Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Exposure to a Case: <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Confirmed Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No Case Number (if applicable):	
Vaccine Request Information			
JYENNOS Vaccine Dose 1: <input type="checkbox"/> Yes <input type="checkbox"/> No		JYENNOS Vaccine Dose 2: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vaccination to occur within 8 weeks of receiving: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Indication: <input type="checkbox"/> Monkeypox <input type="checkbox"/> Smallpox <input type="checkbox"/> PrEP <input type="checkbox"/> PEP		Patient 18 years or older: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Dose 1 Requested:		Number of Dose 2 Requested:	
Antiviral Request Information			
TYPOXX (Tecovirimat) Dose 1: <input type="checkbox"/> Yes <input type="checkbox"/> No		TYPOXX (Tecovirimat) Dose 2: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Dose 1 Requested:		Number of Dose 2 Requested:	
Additional Information for Consideration:			
Contacts of Known Exposure			
Contact Risk Level: High <input type="checkbox"/> Intermediate <input type="checkbox"/> Low <input type="checkbox"/>		Exposure to a Case: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vaccine Request Information			
Vaccination to occur within 8 weeks of receiving: <input type="checkbox"/> Yes <input type="checkbox"/> No			
JYENNOS Vaccine Dose 1: <input type="checkbox"/> Yes <input type="checkbox"/> No		JYENNOS Vaccine Dose 2: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Indication: <input type="checkbox"/> Monkeypox <input type="checkbox"/> Smallpox <input type="checkbox"/> PrEP <input type="checkbox"/> PEP		Patient 18 years or older: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Dose 1 Requested:		Number of Dose 2 Requested:	
MPX Testing Supplies Request			
MPX Testing Supplies Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Normal resource chain exhausted <input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of Testing supplies needed:			
NOTE If additional PPE is needed, provide must fill out SHOC Resource Request Form (separate form).			
Delivery Site Information (one delivery site per form)			
Delivery Address (include facility name, street, city, state and zip):			
Delivery Site POC (Point of Contact):		Email:	
POC 24-hour Phone #:	POC Mobile #:	POC Fax #:	

Additional Information or Comments:	
POD Type/Method	
For any doses that will be given outside your clinic/office walls and/or for which you are working with a partner (e.g., bringing a church group into your clinic or partnering with a community based organization or partner to deliver the vaccine in an off-site location), please complete the following:	
POD Type/Method: <input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Drive-thru <input type="checkbox"/> Walk-up <input type="checkbox"/> Other	
Target population list all that apply:	
Date of event:	Partner name:
Number of doses:	Dose type: <input type="checkbox"/> 1 st dose <input type="checkbox"/> 2 nd dose
Remainder of Document Internal Processing	
Verification	
JYENNOS Dose 1: <input type="checkbox"/> Yes <input type="checkbox"/> No	JYENNOS Dose 2: <input type="checkbox"/> Yes <input type="checkbox"/> No
TPOXX Dose 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	TPOXX Dose 2: <input type="checkbox"/> Yes <input type="checkbox"/> No
Specimen Collection Kits Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ability to fill request/Allocation Group	
<input type="checkbox"/> In entirety <input type="checkbox"/> Partially <input type="checkbox"/> Pending <input type="checkbox"/> Redirected <input type="checkbox"/> Other	
Comments (<i>why partial pending, redirected or other</i>)	
Send to DelVAX or SHOC Logistics for action	
Received by:	
Vaccine Unit Director Recommendation:	Date and Time:
Vaccine Unit Director Signature:	