



Mumps

County _____

LHJ Use ID _____
 Reported to DOH Date ____/____/____
 LHJ Classification Confirmed
 Suspect Probable
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____ Investigation start date ____/____/____
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

OK to talk to case? Yes No DK Date of interview ____/____/____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

Onset date: ____/____/____ Derived Diagnosis date: ____/____/____ Illness duration: ____ days

Signs and Symptoms

Y N DK NA
 Swollen salivary glands (parotitis)
 Fever Highest measured temp: ____ °F
 Type: Oral Rectal Other: ____ Unk
 Seizures new with disease
 Hearing loss resulting from current illness

Clinical Findings

Y N DK NA
 Parotitis Onset date: ____/____/____
 Parotitis lasting 2 days or more
 Encephalitis or encephalomyelitis
 Meningitis
 Acute pancreatitis
 Orchitis
 Mastitis
 Complications
 Specify: _____

Hospitalization

Y N DK NA
 Hospitalized at least overnight for this illness
 Hospital name _____
 Admit date ____/____/____ Discharge date ____/____/____
 Y N DK NA
 Died from illness Death date ____/____/____
 Autopsy Place of death _____

Vaccination

Y N DK NA
 Ever received mumps containing vaccine
 Dose 1 Type: _____ Date received: ____/____/____
 Dose 2 Type: _____ Date received: ____/____/____
 Dose 3 Type: _____ Date received: ____/____/____
 Y N DK NA
 Vaccine up to date for mumps
 Number doses on or after first birthday: _____
 Vaccine series not up to date reason:
 Religious exemption
 Medical contraindication
 Philosophical exemption
 Previous infection confirmed by laboratory
 Previous infection confirmed by physician
 Parental refusal
 Other: _____
 Unk
 Primary vaccine series complete

Laboratory

Collection date ____/____/____
 Source _____

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

P N I O NT
 Mumps PCR
 Mumps virus culture (clinical specimen)
 Mumps IgM First specimen date ____/____/____
 Mumps IgM First specimen date ____/____/____
 Mumps IgM Second specimen date ____/____/____
 Mumps IgG Second specimen date ____/____/____
 Mumps IgG with significant rise (acute and convalescent serum pair)

INFECTION TIMELINE

Enter onset date (first symptom) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset: -25 -12 3 days prior to onset parotitis and 5 days after onset of parotitis

Calendar dates:

EXPOSURE (Refer to dates above)

| | |
|---|--|
| <p>Y N DK NA</p> <p><input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input checked="" type="checkbox"/> Country Destinations/Dates: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the case know anyone else with similar symptoms or illness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with confirmed or probable case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with recent foreign arrival Specify country: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____</p> | <p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congregate living <input type="checkbox"/> Barracks <input type="checkbox"/> Corrections <input type="checkbox"/> Long term care <input type="checkbox"/> Dormitory <input type="checkbox"/> Boarding school <input type="checkbox"/> Camp <input type="checkbox"/> Shelter <input type="checkbox"/> Other: _____</p> <p><input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Exposure setting identified: <input checked="" type="checkbox"/> Child care <input type="checkbox"/> School <input type="checkbox"/> Doctor's office <input checked="" type="checkbox"/> Hospital ward <input type="checkbox"/> Hospital ER <input checked="" type="checkbox"/> Hospital outpatient clinic <input type="checkbox"/> Home <input checked="" type="checkbox"/> College <input type="checkbox"/> Work <input type="checkbox"/> Military <input checked="" type="checkbox"/> Correction facility <input type="checkbox"/> Church <input checked="" type="checkbox"/> International travel <input checked="" type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed or probable case</p> |
|---|--|

Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PUBLIC HEALTH ISSUES

Y N DK NA

Attends child care or preschool

Employed in child care or preschool

Do any household members work at or attend child care or preschool

Documented transmission from this case
 Child care School Doctor's office
 Hospital ward Hospital ER
 Hospital outpatient clinic Home
 College Work Military
 Correction facility Church
 International travel Other: _____ Unk

PUBLIC HEALTH ACTIONS

Exclude exposed susceptibles from work/school for incubation period

NOTES

| | | |
|---------------------------------|--------------------|---|
| Investigator _____ | Phone/email: _____ | Investigation complete date ___/___/___ |
| Local health jurisdiction _____ | | Record complete date ___/___/___ |