

# Mumps

\_\_\_\_\_ COUNTY

**FOR STATE USE ONLY**

# \_\_\_\_\_

\_\_\_/\_\_\_/\_\_\_ case report

- confirmed
- presumptive
- suspect

\_\_\_/\_\_\_/\_\_\_ interstate

Date investigation initiated \_\_\_\_\_

## CASE IDENTIFICATION

Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address \_\_\_\_\_  
Street City Zip

\_\_\_\_\_ language spoken \_\_\_\_\_

ALTERNATIVE CONTACT:  Parent  Spouse  Household Member  Friend  \_\_\_\_\_

Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
indicate home (H); work (W); message (M)

Address \_\_\_\_\_  
Street City Zip

## SOURCES OF REPORT (check all that apply)

- Lab  Infection Control Practitioner
- Physician  \_\_\_\_\_

Name \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
(first report)

Primary M.D. \_\_\_\_\_  
(if different)

Phone \_\_\_\_\_ OK to talk to patient?

## DEMOGRAPHICS

SEX  
 female  male

HISPANIC  yes  no  unknown

RACE

- White  American Indian
- Black  Asian/Pacific Islander
- unknown  refused to answer
- other \_\_\_\_\_

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_  
m d y

or, if unknown, AGE \_\_\_\_\_

Worksites/school/day care center \_\_\_\_\_

Occupations/grade \_\_\_\_\_

## BASIS OF DIAGNOSIS

### CLINICAL DATA

Parotitis  yes  no  unk *if yes, ONSET* \_\_\_/\_\_\_/\_\_\_  
m d y  
 unilateral  bilateral

Duration of parotitis > 2 days?  yes  no  unk

Total duration of parotitis \_\_\_\_\_ (number of days)

Other salivary glands  yes  no  unk *if yes, ONSET* \_\_\_/\_\_\_/\_\_\_  
m d y

Fever  yes  no  unk highest measured \_\_\_\_\_

subjective?

tactile?

Other symptoms (list) \_\_\_\_\_

### COMPLICATIONS

Meningitis  yes  no  unk Oophoritis  yes  no  unk

Deafness  yes  no  unk Encephalitis  yes  no  unk

*if yes, still present?*  yes  no Hospitalized  yes  no  unk

Orchitis  yes  no  unk *if yes, how many days* \_\_\_\_\_

Mastitis  yes  no  unk Name of Hospital \_\_\_\_\_

Nephritis  yes  no  unk Death  yes  no  unk

Pancreatitis  yes  no  unk

## LABORATORY DATA

Lab name \_\_\_\_\_

### Virus Isolation

pos neg not done unk

Buccal swab: \_\_\_/\_\_\_/\_\_\_  
m d y

Urine: \_\_\_/\_\_\_/\_\_\_  
m d y

### PCR

pos neg not done unk

Buccal swab: \_\_\_/\_\_\_/\_\_\_  
m d y

Urine: \_\_\_/\_\_\_/\_\_\_  
m d y

### Serology

pos neg not done unk

Date IgM specimen taken \_\_\_/\_\_\_/\_\_\_  
m d y

Date IgG Acute specimen taken \_\_\_/\_\_\_/\_\_\_  
m d y

Date IgG Convalescent specimen taken \_\_\_/\_\_\_/\_\_\_  
m d y

## EPI-LINKAGE *if yes to any question, give names, contact information, and other relevant details:*

During the exposure period, was the patient

- associated with a known outbreak
- a close contact of a *confirmed* or *presumptive* case
- was source case reported?  yes  not yet

Is the patient aware of anyone with a similar illness?  yes  no

Specify nature of contact:  hospital  day care  work  school  college  doctor's office  other \_\_\_\_\_



PATIENT'S NAME >

**IMMUNIZATION HISTORY**

Mumps-containing vaccine received in the past?  yes  no  unk  
 if yes, complete table:

Vaccine	Date	Provider/Phone	Verified	
			yes	no
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	___/___/___	_____	<input type="checkbox"/>	<input type="checkbox"/>

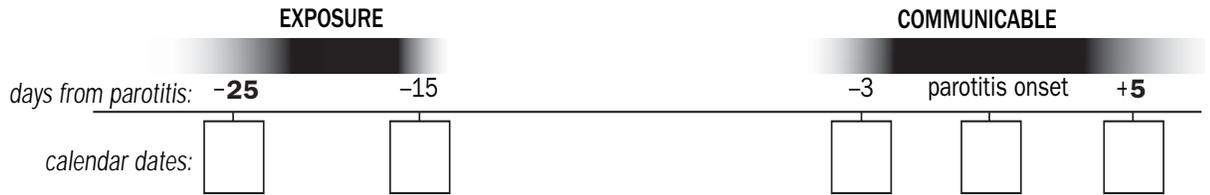
If available, provide details.

if not vaccinated, why not?

- under age for vaccination
- medical exemption
- "religious" objection
- "forgot"
- cost too much
- inconvenience
- concurrent illness
- laboratory evidence of previous disease
- MD diagnosis of previous disease
- other \_\_\_\_\_

**INFECTION TIMELINE**

Enter onset date of parotitis in heavy box. Count forwards and backwards to figure probable exposure and communicable periods.



**POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD**

Skip this section if the case was already epi-linked.

- contact of **suspect** case
- visit to doctor's office/clinic
- visit to emergency room
- travel outside Oregon
- other \_\_\_\_\_
- no exposure identified
- patient could not be interviewed

**CASE CONTACT MANAGEMENT/FOLLOW-UP**

Case education provided?  yes  no  unknown if yes, date \_\_\_/\_\_\_/\_\_\_

Evaluate the immune status of household and other close contacts. Attach additional sheets if necessary.

Name	Relation to Case	Age	Mumps Hx			Vaccination Hx			Dates	Reported by	Education Provided		
			yes	no	unk	yes	no	unk			yes	no	unk
_____	_____	___	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
_____	_____	___	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
_____	_____	___	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
_____	_____	___	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
_____	_____	___	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
_____	_____	___	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Were control measures initiated within 24 hours?  yes  no

Investigate likely sites of transmission. For each site, specify if not applicable (NA), investigated but no other follow-up required (no F/U), or, more follow-up required (F/U). If additional F/U is indicated, provide details. Relevant details include dates, locations, facilities, names and phone numbers of contact persons, the nature of the exposure, etc. Summarize results of the follow-up (number of contacts identified, at risk, vaccinated, etc.). Attach sheets if necessary.

- |                             |                                 |                              |  |                             |                                 |                              |  |
|-----------------------------|---------------------------------|------------------------------|--|-----------------------------|---------------------------------|------------------------------|--|
| <input type="checkbox"/> NA | <input type="checkbox"/> no F/U | <input type="checkbox"/> F/U | <input type="checkbox"/> daycare/preschool | <input type="checkbox"/> NA | <input type="checkbox"/> no F/U | <input type="checkbox"/> F/U | <input type="checkbox"/> hospital              |
| <input type="checkbox"/>    | <input type="checkbox"/>        | <input type="checkbox"/>     | <input type="checkbox"/> school/college    | <input type="checkbox"/>    | <input type="checkbox"/>        | <input type="checkbox"/>     | <input type="checkbox"/> travel outside Oregon |
| <input type="checkbox"/>    | <input type="checkbox"/>        | <input type="checkbox"/>     | <input type="checkbox"/> worksite          | <input type="checkbox"/>    | <input type="checkbox"/>        | <input type="checkbox"/>     | <input type="checkbox"/> _____                 |

**ADMINISTRATION**

Remember to copy patient's name to the top of this page.

Completed by \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_ Case report sent to OHS on \_\_\_/\_\_\_/\_\_\_ Investigation sent to OHS on \_\_\_/\_\_\_/\_\_\_

