



MUMPS CASE REPORT

PATIENT DEMOGRAPHICS

Patient name—last		first	middle initial	Date of birth ____/____/____	Age (enter age and check one) ____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Address—number, street				City	State	ZIP code	County	
Telephone number Home ()				Work ()		Email:		
ETHNICITY (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/ Non-Latino <input type="checkbox"/> Unknown		RACE (check all that apply) <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <input type="checkbox"/> Asian: <i>Please specify:</i> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other Asian: _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Pacific Islander: <i>Please specify:</i> <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander: _____						
Country of birth					Country of residence			

COMMON LHD TRACKING DATA

CMRID Number	IZB Case ID Number	WebCMR ID Number	
Date reported to county ____/____/____	Date investigation started ____/____/____	Person/clinician reporting case	Reporter telephone ()
Case investigator completing form	Investigator telephone ()	Investigator's jurisdiction	

SIGNS AND SYMPTOMS

Parotitis or salivary gland swelling <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Swelling onset date ____/____/____	Swelling duration _____ days	Upper respiratory infection symptoms (e.g., sore throat, cough) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	onset: ____/____/____
Other symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other symptoms		Other symptom onset date ____/____/____	Diagnosis date ____/____/____
Does case meet clinical criteria for further investigation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			CASE MEETS CDC/CSTE CLINICAL CRITERIA? (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

COMPLICATIONS AND OTHER SYMPTOMS

Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Days hospitalized	Meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Orchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other complications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Describe other complications		Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date of death ____/____/____
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other High Risk (healthcare worker, college student) <input type="checkbox"/> Yes _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown		

LABORATORY TESTS

Any lab tests done for mumps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR LHD USE) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	CASE LAB CONFIRMED (FOR STATE USE ONLY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	LAB RESULT CODES P = Positive N = Negative – Antibody not detected I = Indeterminate E = Pending X = Not Done U = Unknown	
Serology performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen date ____/____/____	Result interpretation <input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U		
IgM	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U		
IgG (acute)	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U		
IgG (convalescent)	____/____/____	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> E <input type="checkbox"/> X <input type="checkbox"/> U		
Specimen collected for PCR? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen Source <input type="checkbox"/> Buccal <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Specimen date ____/____/____	PCR result <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Name of Lab:
Virus isolation attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specimen Source <input type="checkbox"/> Buccal <input type="checkbox"/> Urine <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Specimen date ____/____/____	Virus isolated <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Name of Lab:
Specimen sent for genotyping <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date sent ____/____/____	Virus Genotype		
Other lab tests performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other lab test specimen date ____/____/____	Specify other lab tests	Other lab test results	

VACCINATION/MEDICAL HISTORY

Received one or more doses of mumps containing vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of doses
Dates of vaccination—Dose 1 ___/___/___	Dose 2 ___/___/___
Dose 3 ___/___/___	
Reason not vaccinated (check all that apply)	
1 <input type="checkbox"/> Personal Beliefs Exemption (PBE)	4 <input type="checkbox"/> Lab confirmation of previous disease
2 <input type="checkbox"/> Permanent Medical Exemption (PME)	5 <input type="checkbox"/> MD diagnosis of previous disease
3 <input type="checkbox"/> Temporary Medical Exemption	6 <input type="checkbox"/> Under age for vaccination
	7 <input type="checkbox"/> Delay in starting series or between doses
	8 <input type="checkbox"/> Other
	9 <input type="checkbox"/> Unknown

EPIDEMIOLOGICAL EXPOSURE HISTORY

Acquisition Setting (check all that apply)

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital Ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional facility	15 <input type="checkbox"/> Other

Other significant exposures:

Recent travel or arrival from other country or state within 25 days of parotitis onset? Yes No Unknown

Countries or states visited	Dates in countries or states visited	Date of arrival in California ___/___/___
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Close contact with person(s) with mumps 14-25 days before parotitis onset? Yes No Unknown

Name	Parotitis Onset Date	Relationship	Age (Years)	Same Household
1	___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2	___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3	___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing work sheet.

Epi-linked to a lab-confirmed case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Case Name or Case ID	Outbreak related <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Outbreak Name or Location
Import status <input type="checkbox"/> Indigenous <input type="checkbox"/> Out-of-state import <input type="checkbox"/> International Import	If case is indigenous, is case <input type="checkbox"/> Import-linked (linked to imported case) <input type="checkbox"/> Endemic <input type="checkbox"/> Unknown Source <input type="checkbox"/> Imported virus (viral genetic evidence indicates an imported genotype)		If case is Import, describe source

CONTACT INVESTIGATION

Spread Setting (check all that apply)

1 <input type="checkbox"/> Day care	4 <input type="checkbox"/> Hospital Ward	7 <input type="checkbox"/> Home	10 <input type="checkbox"/> College	13 <input type="checkbox"/> Church
2 <input type="checkbox"/> School	5 <input type="checkbox"/> Hospital ER	8 <input type="checkbox"/> Work	11 <input type="checkbox"/> Military	14 <input type="checkbox"/> International travel
3 <input type="checkbox"/> Doctor's office	6 <input type="checkbox"/> Outpatient hospital clinic	9 <input type="checkbox"/> Unknown	12 <input type="checkbox"/> Correctional facility	15 <input type="checkbox"/> Other

Number of susceptible contacts: _____

Close contacts who have mumps 14-25 days after exposure to case (list below)
 Yes No Unknown

Name	Parotitis onset date	Relationship	Age (Years)	Same Household
1	___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
2	___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3	___/___/___			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Please list other contacts on a separate sheet or use the contact tracing work sheet.

CASE CLASSIFICATION (FOR LHD USE) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown	CASE CLASSIFICATION (FOR STATE USE ONLY) <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
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MUMPS CASE DEFINITION

Clinical case definition: An illness with acute onset of unilateral or bilateral tender, self-limited swelling of the parotid and or other salivary gland(s), lasting at least 2 days, and without other apparent cause.

Clinically compatible illness: Infection with mumps virus may present as aseptic meningitis, encephalitis, hearing loss, orchitis, oophoritis, parotitis or other salivary gland swelling, mastitis or pancreatitis.

Laboratory criteria: Isolation of mumps virus from clinical specimen, OR detection of mumps nucleic acid (e.g., standard or real time RT-PCR assays), OR detection of mumps IgM antibody, OR demonstration of specific mumps antibody response in absence of recent vaccination, either a four-fold increase in IgG titer as measured by quantitative assays, or a seroconversion from negative to positive using a standard serologic assay of paired acute and convalescent serum specimens.

Case Classification
Suspected: Parotitis, acute salivary gland swelling, orchitis, or oophoritis unexplained by another more likely diagnosis, or a positive lab result with no mumps clinical symptoms (with or without epidemiological linkage to a confirmed or probable case).
Probable: Acute parotitis or other salivary gland swelling lasting at least 2 days, or orchitis or oophoritis unexplained by another more likely diagnosis, in either a person with a positive test for serum anti-mumps IgM antibody, or a person with epidemiologic linkage to another probable or confirmed case or linkage to a group/community defined by public health during an outbreak of mumps.
Confirmed: A positive mumps laboratory confirmation for mumps virus with RT-PCR or culture in a patient with an acute clinically compatible mumps illness