Mumps Surveillance Worksheet

NAME _____ (last) _____ (first) **ADDRESS (Street and No.)** _____ **Phone** _____ **Hospital Record No.** _____

This information will not be sent to CDC

REPORTING SOURCE TYPE
☐ physician ☐ PH clinic
☐ nurse ☐ laboratory
☐ hospital ☐ other clinic
☐ other source type _____

NAME _____
ADDRESS _____
ZIP CODE _____
PHONE (__ __ __) __ __ __ __ __ __ __

SUBJECT ADDRESS CITY _____
SUBJECT ADDRESS STATE _____
SUBJECT ADDRESS COUNTY __ __ __ __ __
SUBJECT ADDRESS ZIP CODE _____
LOCAL SUBJECT ID _____

CASE INFORMATION

Case Class Status
☐ Confirmed ☐ Suspected
☐ Probable ☐ Unknown
☐ Not a case

Date First Reported __ __ __ __ __ __ __ __ (month day year)

Date Reported to County __ __ __ __ __ __ __ __ (month day year)

Date First Reported to PHD __ __ __ __ __ __ __ __ (month day year)

Earliest Date Reported to State __ __ __ __ __ __ __ __ (month day year)

Reporting State _____

Reporting County _____

National Reporting Jurisdiction _____

Age at Case Investigation _____
Age Unit* _____

DATE OF BIRTH __ __ __ __ __ __ __ __ (month day year)

SEX M=male F=female ☐ U=unknown

RACE (select all that apply)
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused to answer
☐ Not asked ☐ Other _____ ☐ Unknown

Country of Birth _____

Other Birth Place _____

Country of Usual Residence _____

Ethnic Group ☐
H=Hispanic or Latino **N**=not Hispanic/Latino **O**=other _____ **U**=unknown

CLINICAL INFORMATION

Illness Onset Date __ __ __ __ __ __ __ __ (month day year)

Illness Duration _____

Duration Units* _____

Illness End Date __ __ __ __ __ __ __ __ (month day year)

Diagnosis Date __ __ __ __ __ __ __ __ (month day year)

Pregnancy Status Y=yes N=no U=unknown ☐

SIGNS and SYMPTOMS

	Y	N	U
Fever			
Headache			
Jaw pain			
Loss of appetite			
Muscle pain			
Parotitis			
Sublingual salivary gland swelling			
Submandibular salivary gland swelling			
Tiredness			
Other (specify) _____			

Y=yes N=no U=unknown

SALIVARY GLAND SWELLING

	ONSET DATE	DURATION
Submandibular	__ __ __ __ __ __ __ __ (month day year)	_____ (days)
Sublingual	__ __ __ __ __ __ __ __ (month day year)	_____ (days)

Date of Fever Onset __ __ __ __ __ __ __ __ (month day year)

Parotitis (laterally)
☐ bilateral ☐ other
☐ unilateral ☐ unknown

Highest Temperature _____ . ____

Temperature Units ☐ °Cel ☐ °F

COMPLICATIONS

Hospitalized? Y=yes N=no U=unknown ☐

Hospital Admission Date __ __ __ __ __ __ __ __ (month day year)

Hospital Discharge Date __ __ __ __ __ __ __ __ (month day year)

Duration of Hospital Stay 0 – 998 days 999=unknown _____ days

Subject Died? Y=yes N=no U=unknown ☐

Deceased Date __ __ __ __ __ __ __ __ (month day year)

Type of Complications

Y	N	U	
			Deafness
			Encephalitis
			Meningitis
			Orchitis
			Other _____
			Unknown

Y=yes N=no U=unknown

Type of Deafness
☐ permanent
☐ temporary
☐ other _____
☐ unknown

*UNITS a=year h=hour mo=month w=week d=day min=minute s=second OTH=other UNK=unknown

LABORATORY TESTING

VPD Lab Message Reference Laboratory	VPD Lab Message Patient Identifier	VPD Lab Message Specimen Identifier	Laboratory Testing to Confirm Diagnosis? Y=yes N=no U=unknown ☐	Was Case Laboratory Confirmed? Y=yes N=no U=unknown ☐	Specimen Sent to CDC? Y=yes N=no U=unknown ☐
_____	_____	_____			

TEST TYPE	TEST RESULT	DATE SPECIMEN COLLECTED	DATE SPECIMEN SENT to CDC	TEST RESULT Quantitative	Result Units	SPECIMEN SOURCE	Performing Laboratory Type
IgM 1 serology	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
IgM 2 serology	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
IgG (acute) **serology**	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
IgG (conv) **seology**	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
IgG (single only)	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
culture	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
genotyping	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
PCR	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
other	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
molecular typing	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____
UNKNOWN	____	__ __ __ __ __ __ __ __ month day year	__ __ __ __ __ __ __ __ month day year	_____	_____	_____	_____

TEST RESULTS CODES
P=positive N=negative X=not done
I=Indeterminate E=pending O=other
NS=no significant rise in titer
PS=significant rise in titer U=unknown

Specimen Source Codes
1=blood 5=saliva 8=other
2=buccal swab 6=tissue 9=unknown
3=crust 7=urine 10=vesicular swab
4=macular scraping

Performing Laboratory Type
1=CDC lab 2=commercial lab
3=hospital lab 4=other clinical lab
5=public health lab 6=VPD testing lab
8=other 9=unknown

IMPORTATION INFORMATION

IMPORTED CODE
1=Indigenous 9=unknown
2=international
3=in state, out of jurisdiction ☐
4=out of state
5=imported, unable to detemine source

IMPORT STATUS:
Did onset occur within 12-25 days of entering the U.S. following any travel? ☐
Y=yes N=no U=unknown

IMPORT STATUS: US-Acquired
1=import-linked case
2=imported virus case ☐
3=endemic case
4=unknown source case
5=other _____

RECENT INTERNATIONAL TRAVEL DESTINATION
_____
_____

IMPORTED COUNTRY
_____

IMPORTED STATE
_____

IMPORTED CITY
_____

IMPORTED COUNTY
_____

LENGTH of TIME in the U.S SINCE LAST TRAVEL _____

UNITS* LENGTH of TIME in the U.S.
_____

RETURN DATE from MOST RECENT TRAVEL __ __ __ __ __ __ __ __
month day year

EXPOSURE INFORMATION

Outbreak Related? Y=yes N=no U=unknown ☐	**Outbreak NAME** ____________________	**TRANSMISSION SETTING** ☐☐ 1 = day care 2 = school 3 = doctor's office 4 = hospital ward 5 = hospital ER 6 = hospital outpatient 7 = home 8 = other ____________ 9 = unknown 10 = college 11 = military 12 = correctional facility 13=church 14 = international travel 15 = community 16 = work 17 = athletics **TRANSMISSION MODE** __ __ __ __ __ __ __ __ __
EPI_LINKED? Y=yes N=no U=Unknown ☐	**CITY of EXPOSURE** ____________________	
COUNTRY of EXPOSURE ____________________	**COUNTY of EXPOSURE** ____________________	**AGE and SETTING VERIFIED? [Does the age of the case match or make sense for the listed transmission setting?]** Y=yes N=no U=unknown ☐
STATE/PROVINCE of EXPOSURE ____________________	**Case Investigation Start Date** __ __ __ __ __ __ __ __ (month day year)	**DETECTION METHOD** ☐ routine physical exam ☐ prison entry screening ☐ provider reported ☐ prenatal testing ☐ other ____________ ☐ self-referral ☐ unknown

VACCINATION HISTORY

VACCINATED? (has the case-patient ever received mumps-containing vaccine?) Y=yes N=no U=unknown ☐	**NUMBER DOSES Received On or After First Birthday** 0 – 6 99 = unknown ☐☐ doses	**NUMBER DOSES Received Prior to Illness Onset** ☐☐ 0–6 99=unknown	**DATE of LAST DOSE Prior to Illness Onset** __ __ __ __ __ __ __ __ (month day year)	**VACCINATED per ACIP Recommendations?** Y=yes N=no U=unknown ☐

Vaccine Type**	Vaccination Date (month day year)	Vaccine Manuf†	Vaccine Lot Number	Vaccine Expiry Date (month day year)	National Drug Code	Vaccination Record Identifier	Vaccine Event Information SourceŦ	Vaccine Dose Number
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___
____	__ __ __ __ __ __ __ __	____	__________	__ __ __ __ __ __ __ __	_______	_________	_______	___

**VACCINE TYPE CODES

A=MMR
B=mumps virus vaccine
MR=M/R
M=measles virus vaccine
R=rubella
O=other
RM=rubella/mumps
MM=MMRV
N=no vaccine administered
U=unknown

†VACCINE MANUFACTURER CODES

M = Merck
O = other
U = unknown

ŦVACCINE EVENT INFORMATION SOURCE CODES

00= new immunization record
01= historical information, source unidentified
02= historical information, other provider
05= historical information, other registry
06= historical information, birth certificate
07= historical information, school record
08= historical information, public agency
09= historical information, patient or parent recall
10= historical information, patient or parent written record
OTH= other
UNK= unknown

REASON NOT VACCINATED PER ACIP ☐☐

1 = religious exemption
2 = medical contraindication
3 = philosophical objection
4 = lab evidence of previous disease
5 = MD diagnosis of previous disease
6 = too young
7 = parent/patient refusal
8 = other ____________________
9 = unknown
10 = parent/patient forgot to vaccinate
11 = vaccine record incomplete/unavailable
12 = parent/patient report of previous disease
13 = parent/patient unaware of recommendation
14 = missed opportunity
15 = foreign visitor
16 = immigrant

VACCINE HISTORY COMMENTS

CASE NOTIFICATION

Condition Code	Local Record ID	Legacy Case ID	State Case ID	Binational Reporting Criteria
10180	_____	_____	_____	__ __ __ __ __ __ __

Date First Verbal Notification to CDC	Date First Electonically Reported	Date of Electronic Case Notification to CDC	Person Reporting to CDC Phone Number
-- -- -- -- -- -- -- -- month day year	-- -- -- -- -- -- -- -- month day year	-- -- -- -- -- -- -- -- month day year	(__ __ __) __ __ __ __ __ __ __ Area code

Jurisdiction Code _____	MMWR WEEK ____	MMWR YEAR _____	Immediate National Notifiable Condition ☐ Y=yes N=no U=unknown	Person Reporting to CDC NAME _____ (first) _____ (last)

Current Occupation	Current Occupation Standardized	Current Industry	Current Industry Standardized	Person Reporting to CDC Email
_____ _____	_____ _____	_____ _____	_____ _____	_____

COMMENTS

CLINICAL CASE DEFINITION §

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:
  - A person with a positive test for serum anti-mumps immunoglobulin M (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 reverse transcription polymerase chain reaction (RT-PCR) or culture in a patient with an acute illness characterized by any of the following:

  - Acute parotitis or other salivary gland swelling, lasting at least 2 days
  - Aseptic meningitis
  - Encephalitis
  - Hearing loss
  - Orchitis
  - Oophoritis
  - Mastitis
  - Pancreatitis

§CSTE Position Statement 11-ID-18 at http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/PS/11-ID-18.pdf