WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Mumps

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address: _____
City/State/Zip: _____
Phone (home): _____ Phone (work) : _____
Occupation/grade: _____ Employer/School: _____
Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: _____ *Phone:* _____

*Birth date: __/__/____ Age: _____
*Gender: ☐Male ☐Female ☐Unk
*Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
*Race: (Mark all that apply) ☐White ☐Black/Afr. Amer. ☐Asian ☐Am. Ind/AK Native ☐Native HI/Other PI ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigator : _____
Investigator phone: _____
Investigation Start Date: / / _____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
WVEDSS ID: _____
Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case ☐ Unknown

REPORTING SOURCE

*Date of report: __/__/____ Report Source: ☐Laboratory ☐Hospital ☐Physician ☐Public Health Agency ☐Other
Report Source Name: _____ Address: _____ Phone: _____
Earliest date reported to LHD: / / _____ Earliest date reported to DIDE: / / _____
Reporter Name: _____ Address: _____ Phone: _____

*CLINICAL

Physician Name: _____ Physician Facility : _____
Physician Address: _____ Phone: _____

Hospital *Was patient hospitalized for a mump-related complication? ☐ **Y** ☐ **N** ☐ **U**
If yes: Hospital Name: _____ Address: _____ Phone: _____
Admit date: / / _____ Discharge date: / / _____

Condition Diagnosis date: __/__/____ * Illness onset date: __/__/____ Illness end date: / / _____

Y	N	U	
☐	☐	☐	Is the patient pregnant?
☐	☐	☐	Does the patient have pelvic inflammatory disease?
☐	☐	☐	Did the patient die from this illness?

Symptoms

Y	N	U	
☐	☐	☐	Parotid swelling (parotitis)? Date of onset: __/__/____ Is swelling: ☐ Unilateral ☐ Bilateral Duration (in days): _____
☐	☐	☐	Sublingual or submaxillary swelling?
☐	☐	☐	Headache?
☐	☐	☐	Fever? Highest recorded temperature: ____° ☐ Fahrenheit ☐ Celsius Date of highest recorded temperature: / / _____
☐	☐	☐	Malaise?
☐	☐	☐	Myalgias?
☐	☐	☐	Arthritis/Arthralgias?
☐	☐	☐	Abdominal/pelvic pain?
☐	☐	☐	Other signs/symptoms? Specify: _____

List medication(s) given: _____ Duration of treatment (in days): _____

Complications

Y	N	U		Y	N	U		Y	N	U		Y	N	U	
☐	☐	☐	Aseptic Meningitis	☐	☐	☐	Encephalitis	☐	☐	☐	Orchitis	☐	☐	☐	Oophoritis
☐	☐	☐	Mastitis	☐	☐	☐	Pancreatitis	☐	☐	☐	Nephritis	☐	☐	☐	Myocarditis
☐	☐	☐	Deafness*	☐	☐	☐	Arthropathy**	☐	☐	☐	Other (specify) _____				

* If yes, was deafness: ☐ Transient (resolved) ☐ Permanent ☐ Unknown
**If yes, was arthropathy: ☐ Polyarticular migratory ☐ Monoarticular

List underlying chronic medical conditions: _____
List concurrent acute medical conditions: _____

Y=Yes N=No U=Unknown
*required surveillance indicator

*LABORATORY *(Please submit copies of all labs to DIDE)*

Was lab testing for mumps done? ☐ **Y** ☐ **N** ☐ **U** Type of testing done: ☐ IgM ☐ Acute IgG ☐ Convalescent IgG ☐ Viral Isolation

Results:
IgM: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate ☐ Unknown ☐ Not done IgM specimen collection date:_/_/________

Acute IgG: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Unknown ☐ Not done Acute specimen collection date:_/_/_________
Acute vs. Convalescent IgG: ☐ Significant rise in IgG ☐ No significant rise in IgG
☐ Indeterminate ☐ Pending ☐ Unknown ☐ Not done Convalescent specimen collection date: / /________

Mumps viral isolation collection date:_/_/________Specimen type: ☐ Buccal swab ☐ Nasopharyngeal swab ☐ Blood ☐ Urine
Mumps viral isolation result: ☐ Positive ☐ Negative ☐ Pending ☐ Indeterminate ☐ Unknown ☐ Not done

Lumbar puncture: ☐ Done ☐ Not done ☐ Unknown Result: ____________________
Urine analysis: ☐ Done ☐ Not done ☐ Unknown Result: ____________________
Creatinine: ☐ Done ☐ Not done ☐ Unknown Result: ____________________
EKG: ☐ Done ☐ Not done ☐ Unknown Result: ____________________

VACCINE INFORMATION

*Did the patient ever receive a mumps-containing vaccine? ☐ **Y** ☐ **N** ☐ **U** If yes: Number of doses received BEFORE 1st birthday? _
If not vaccinated, what was the reason? Number of doses received ON or AFTER 1st birthday? ____
☐ Lab evidence of previous disease ☐ MD diagnosis of previous disease ☐ Medical contraindication ☐Parental Refusal
☐ Philosophical objection ☐ Religious exemption ☐ Under age for vaccination ☐ Unknown ☐ Other (specify) _____________

VACCINATION RECORD

Date received:_/_/________Anatomical site: __________________ Vaccine administered:_______________Vaccine ID: ___________ Manufacturer:_________________Organization ID: ___________ Lot #:___________________ Expiration Date:_/_/________	**Given by:** Last Name: ___________________________ First Name:______________________Provider ID: ____________ Organization Name: ______________________________________ Organization ID: __________________
Date received:_/_/________Anatomical site: __________________ Vaccine administered:_______________Vaccine ID: ___________ Manufacturer:_________________Organization ID: ___________ Lot #:___________________ Expiration Date:_/_/________	**Given by:** Last Name: ___________________________ First Name:______________________Provider ID: ____________ Organization Name: ______________________________________ Organization ID: __________________
Date received:_/_/________Anatomical site: __________________ Vaccine administered:_______________Vaccine ID: ___________ Manufacturer:_________________Organization ID: ___________ Lot #:___________________ Expiration Date:_/_/________	**Given by:** Last Name: ___________________________ First Name:______________________Provider ID: ____________ Organization Name: ______________________________________ Organization ID: __________________

EPIDEMIOLOGIC

Y	N	U	
☐	☐	☐	Is the patient associated with a daycare facility? If yes, name of facility: ____________________
☐	☐	☐	Is the patient a food handler? If yes, name of establishment: ____________________
☐	☐	☐	* Is this case part of an outbreak? If yes, name of outbreak: ____________________
☐	☐	☐	*Is the patient epi-linked to another confirmed or probable case?
☐	☐	☐	Were age and setting verified?
☐	☐	☐	Does the patient attend college? If yes, name of college: ____________________
☐	☐	☐	Is the patient currently employed? If yes, name of company: ____________________
☐	☐	☐	Is the patient a healthcare worker? If yes, name of facility: ____________________

Where was the disease acquired? ☐ Indigenous, within jurisdiction ☐ Out of country ☐ Out of jurisdiction, from another jurisdiction
☐ Out of state ☐ Unknown

Source of exposure for current case (A source case must be either a confirmed or probable case and have had face-to-face contact with a subsequent generation case and exposure must have occurred 7-18 days before onset of symptoms in the new case and between 4 days before onset of symptoms and 7 days after onset of symptoms of the source case.) *(Enter state if source was out-of-state; enter country if source was out of the US; enter city information if known)*

*Transmission mode: ☐ Airborne ☐ Bloodborne ☐ Dermal ☐ Foodborne ☐ Mechanical ☐ Nosocomial ☐ Sexually transmitted
☐ Transplacental transmission ☐ Vector borne ☐ Waterborne ☐ Zoonotic ☐ Indeterminate ☐ Other (specify): __________________

Detection method:
☐ Patient self-referral ☐ Prenatal testing ☐ Prison entry screening ☐ Provider reported ☐ Routine physical ☐ Other

Confirmation method:

☐ Active surveillance	☐ Case/Outbreak management	☐ Clinical diagnosis (not lab confirmed)	☐ Epidemiologically linked
☐ Lab confirmed	☐ Lab report	☐ Local/State specified	☐ Medical record review
☐ No information given	☐ Occupational disease surveillance	☐ Provider certified	☐ Other (specify): ________________

Y=Yes N=No U=Unknown
*required surveillance indicator

Confirmation date: _/_/_____

TRAVEL HISTORY

Has patient had recent contact with a traveler? ☐ **Y** ☐ **N** ☐ **U** If yes, specify: _____

Does patient have a history of recent travel? ☐ **Y** ☐ **N** ☐ **U** If yes, was travel: ☐ International ☐ Domestic

List travel history, including dates of departure/return, location(s), and mode(s) of transportation, within 25 days of symptom onset:

ACTIVITY HISTORY **(list all group activities of patient 18 days before symptom onset such as sporting events, extracurricular event, vacation, holidays, breaks)**

Date	Activity	Location

PUBLIC HEALTH ACTIONS/NOTES

Y N U

☐ ☐ ☐ Lost to follow-up

☐ ☐ ☐ Disease education and prevention information provided to patient and/or family/guardian?
*If yes, specify date __/__/____.

Y=Yes N=No U=Unknown

*required surveillance indicator

*Contact Tracing Sheet									
Name/Contact Information (including guardian info for minors)	Sympto-matic? (Y/N)	Date of Birth (mm/dd/yyyy)	Sex	Relation-ship to case?	Number of doses of mumps-containing vaccine?	Date(s) of vaccination (mm/dd/yyyy)	History of disease diagnosed by healthcare provider? (Y/N)	Lab tests performed? (Y/N)	Parotitis onset date? **(mm/dd/yyyy)**

Number of contacts in any setting recommended PEP: _____

Y=Yes N=No U=Unknown
*required surveillance indicator