



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF SURVEILLANCE

MUMPS REPORT

CASE NO. _____

PATIENT	NAME (LAST, FIRST, M.I.)			COUNTY
	ADDRESS	CITY	STATE	ZIP CODE
Reporting Physician Nurse/Hosp/ Clinic	NAME			
	ADDRESS	CITY	STATE	ZIP CODE

DEMOGRAPHICS

BIRTHDATE (MONTH/DAY/YEAR)	RACE	ETHNICITY
SEX	<input type="checkbox"/> N - NATIVE AMER./ALASKAN NATIVE <input type="checkbox"/> W - WHITE <input type="checkbox"/> A - ASIAN/PACIFIC ISLANDER <input type="checkbox"/> O - OTHER <input type="checkbox"/> B - AFRICAN AMERICAN <input type="checkbox"/> U - UNKNOWN	<input type="checkbox"/> H - HISPANIC <input type="checkbox"/> N - NOT HISPANIC <input type="checkbox"/> U - UNKNOWN
<input type="checkbox"/> M - MALE <input type="checkbox"/> F - FEMALE <input type="checkbox"/> U - UNKNOWN		

CLINICAL DATA

EVENT DATE (MONTH/DAY/YEAR)	COMMENTS CONFIRMED (OTHER DATA)	PAROTITIS	IMPORTED
	<input type="checkbox"/> PROBABLE <input type="checkbox"/> SUSPECTED <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> 1 - INDIGENOUS (ACQUIRED IN USA REPORTING STATE) <input type="checkbox"/> 2 - INTERNATIONAL (ACQUIRED OUTSIDE USA) <input type="checkbox"/> 3 - OUT OF STATE (ACQUIRED IN USA OUTSIDE REPORTING STATE) <input type="checkbox"/> 9 - UNKNOWN

COMPLICATIONS

	YES	NO	UNKNOWN		YES	NO	UNKNOWN
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Complication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized due to mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If other complication, specify _____			
Total Days Hospitalized	_____						

LABORATORY

WAS TESTING FOR MUMPS DONE
 YES NO UNKNOWN

DATE IgM SPECIMEN TAKEN MONTH DAY YEAR	IgM RESULT
	<input type="checkbox"/> P - POSITIVE <input type="checkbox"/> N - NEGATIVE <input type="checkbox"/> I - INDETERMINANT <input type="checkbox"/> E - PENDING <input type="checkbox"/> X - NOT DONE <input type="checkbox"/> U - UNKNOWN
DATE IgG ACUTE SPECIMEN TAKEN MONTH DAY YEAR	IgG RESULT
	<input type="checkbox"/> P - SIGNIFICANT RISE IN IgG <input type="checkbox"/> I - INDETERMINANT <input type="checkbox"/> X - NOT DONE <input type="checkbox"/> N - NO SIGNIFICANT RISE IN IgG <input type="checkbox"/> E - PENDING <input type="checkbox"/> U - UNKNOWN
DATE IgG CONVALESCENT SPECIMEN TAKEN MONTH DAY YEAR	IgG RESULT
	<input type="checkbox"/> P - SIGNIFICANT RISE IN IgG <input type="checkbox"/> I - INDETERMINANT <input type="checkbox"/> X - NOT DONE <input type="checkbox"/> N - NO SIGNIFICANT RISE IN IgG <input type="checkbox"/> E - PENDING <input type="checkbox"/> U - UNKNOWN
SPECIFY OTHER LABORATORY METHODS AND RESULTS	OTHER RESULTS
	<input type="checkbox"/> P - POSITIVE <input type="checkbox"/> N - NEGATIVE <input type="checkbox"/> I - INDETERMINANT <input type="checkbox"/> E - PENDING <input type="checkbox"/> X - NOT DONE <input type="checkbox"/> U - UNKNOWN

VACCINE HISTORY

HAD CASE EVER RECEIVED MUMPS-CONTAINING VACCINE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	NUMBER OF DOSES RECEIVED ON OR AFTER 1ST BIRTHDAY
VACCINATION DATE MONTH DAY YEAR	IF CASE NOT VACCINATED, WHAT WAS THE REASON
1.	<input type="checkbox"/> 1 - RELIGIOUS EXEMPTION <input type="checkbox"/> 2 - MEDICAL CONTRAINDICATION <input type="checkbox"/> 3 - PHILOSOPHICAL OBJECTION <input type="checkbox"/> 4 - LABORATORY EVIDENCE OF PREVIOUS DISEASE <input type="checkbox"/> 5 - DOCTOR DIAGNOSIS OF PREVIOUS DISEASE <input type="checkbox"/> 6 - UNDER AGE FOR VACCINATION <input type="checkbox"/> 7 - PARENTAL REFUSAL <input type="checkbox"/> 8 - OTHER <input type="checkbox"/> 9 - UNKNOWN
2.	
3.	
4.	

EPIDEMIOLOGIC INFORMATION

TRANSMISSION SETTING (WHERE DID THIS CASE ACQUIRE MUMPS?)

- | | | |
|--|---|---|
| <input type="checkbox"/> 1 - DAY CARE | <input type="checkbox"/> 6 - HOSPITAL OUTPATIENT CLINIC | <input type="checkbox"/> 11 - MILITARY |
| <input type="checkbox"/> 2 - SCHOOL | <input type="checkbox"/> 7 - HOME | <input type="checkbox"/> 12 - CORRECTIONAL FACILITY |
| <input type="checkbox"/> 3 - DOCTOR'S OFFICE | <input type="checkbox"/> 8 - WORK | <input type="checkbox"/> 13 - CHURCH |
| <input type="checkbox"/> 4 - HOSPITAL WARD | <input type="checkbox"/> 9 - UNKNOWN | <input type="checkbox"/> 14 - INTERNATIONAL TRAVEL |
| <input type="checkbox"/> 5 - HOSPITAL ER | <input type="checkbox"/> 10 - COLLEGE | <input type="checkbox"/> 15 - OTHER |

IF TRANSMISSION SETTING NOT AMONG THOSE LISTED AND KNOWN, WHAT WAS TRANSMISSION SETTING?

WERE AGE AND SETTING VERIFIED

- YES NO UNKNOWN

OUTBREAK RELATED

- YES NO UNKNOWN

IF YES, OUTBREAK NAME (NAME OF OUTBREAK THIS CASE IS ASSOCIATED WITH)

SOURCE OF EXPOSURE FOR CURRENT CASE

EPI-LINKED TO ANOTHER CONFIRMED OR PROBABLE CASE

- YES NO UNKNOWN

CONTACTS (HOUSEHOLD AND OTHER)

NAME, ADDRESS AND PHONE	AGE	SEX	RELATION TO PATIENT	SIMILAR ILLNESS? ONSET DATE	DATE LABORATORY SPECIMEN COLLECTED	LABORATORY RESULTS

NOTES

Outbreak (Mumps) Cases (with at least one laboratory confirmed case) clustered in space and time.

Source of exposure A source case must be either a confirmed or probable case and have had face to face contact with a subsequent generation case. Exposure must have occurred 7 to 18 days before onset of the new case, and between 4 days before onset and 7 days after the source case.

Epi-linked An epi-linked case is either a source case or same generation case. Epi-linkage is characterized by direct face to face contact. For same generation cases that are epi-linked, a common exposure is likely.

DATE CASE FIRST REPORTED TO STATE MONTH DAY YEAR	FORM COMPLETED BY	TELEPHONE ()	DATE FORM COMPLETED MONTH DAY YEAR
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