Mumps Surveillance Worksheet

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

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

Date of Birth _ _ _ _ _ _ _ _ (month day year)

Sex M=male F=female U=unknown ☐

Ethnic Group H=Hispanic/Latino N=Not Hispanic/Latino O=Other ____ U=Unknown ☐

Race ☐ American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White ☐Not asked ☐ Refused to answer ☐Other ☐ Unknown

Country of Birth ____________ **Other Birth Place** ____________ **Country of Usual Residence** ____________

Age at Case Investigation ______ **Age Unit*** ____ **Reporting County** ____________ **Reporting State** ________

Date Reported _ _ _ _ _ _ _ _ (month day year)

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

National Reporting Jurisdiction _____

Earliest Date Reported to County _ _ _ _ _ _ _ _ (month day year)

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

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

Case Investigation Start Date _ _ _ _ _ _ _ _ (month day year)

Case Investigation Status Code ☐ approved ☐ closed ☐ deleted ☐ in progress ☐ notified ☐ other________ ☐ rejected ☐ reviewed ☐ suspended ☐ unknown

Detection Method ☐ prenatal testing ☐ prison entry ☐ provider report ☐ routine physical ☐ self-referral ☐ other ____________ ☐ unknown

CLINICAL INFORMATION

Hospitalized? Y=yes N=no U=unknown ☐

Hospital Admit Date _ _ _ _ _ _ _ _ (month day year)

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

Hospital Stay Duration 0 – 998 999=unknown ☐☐☐ days

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

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

Illness Duration _____ **Illness Duration Units*** ____

Date of Diagnosis _ _ _ _ _ _ _ _ (month day year)

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

SIGNS and SYMPTOMS

	Y	N	U		Y	N	U
Parotitis				Fever			
Sublingual salivary gland swelling				Jaw pain			
Submandibular salivary gland swelling				Muscle pain			
Headache				Tiredness			
Loss of appetite				Other ____________			

Y=yes N=no U=unknown

Parotitis ☐ bilateral ☐ unilateral ☐ other ☐ unknown

SALIVARY GLAND SWELLING

ONSET DATE _ _ _ _ _ _ _ _ (month day year)

DURATION _______ (days

COMPLICATIONS

	Y	N	U		Y	N	U
Deafness				Orchitis			
Encephalitis				Pancreatitis			
Mastitis				Other ____________			
Meningitis				Unknown			
Oophoritis				Death			

Y=yes N=no U=unknown

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

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

Highest Temperature ________ . ____

Deceased Date _ _ _ _ _ _ _ _ (month day year)

Temperature Units ☐ °Cel ☐ °F

*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
______________________	______________________	______________________

Was there laboratory testing done to confirm the diagnosis? Y=Yes N=No U=Unknown ☐

Was case laboratory confirmed? Y=yes N=no U=unknown ☐

Was a specimen sent to CDC for testing? Y=yes N=no U=unknown ☐

Test Type	Test Result	Test Result Quantitative	Result Units	Specimen Source (Type)	Date Specimen Collected (mm/dd/yyyy)	Date Specimen Sent to CDC (mm/dd/yyyy)	Specimen Analyzed Date (mm/dd/yyyy)	Performing Laboratory Type
IgM 1					__ __ ____	__ __ ____	__ __ ____	
IgM 2					__ __ ____	__ __ ____	__ __ ____	
IgG 1 acute					__ __ ____	__ __ ____	__ __ ____	
IgG conv					__ __ ____	__ __ ____	__ __ ____	
IgG single					__ __ ____	__ __ ____	__ __ ____	
culture					__ __ ____	__ __ ____	__ __ ____	
genotype					__ __ ____	__ __ ____	__ __ ____	
PCR 1					__ __ ____	__ __ ____	__ __ ____	
PCR 2					__ __ ____	__ __ ____	__ __ ____	
other					__ __ ____	__ __ ____	__ __ ____	
unspecified serology					__ __ ____	__ __ ____	__ __ ____	
molecular typing					__ __ ____	__ __ ____	__ __ ____	
unknown					__ __ ____	__ __ ____	__ __ ____	

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
VT=vaccine type strain
WT=wild type strain

Specimen Source Codes

1=bacterial isolate
2=blood
3=body fluid
4=BAL
5=buccal smear
6=buccal swab
7=capillary blood
8=cataract
9=CSF
10=crust
11=DNA
12=lesion
13=macular scraping
14=microbial isolate
15=NP aspirate
16=NP swab
17=NP washing
18=nucleic acid
19=oral fluid
20=oral swab
21=plasma
22=RNA
23=saliva
24=scab
25=serum
26=skin lesion
27=specimen
28=lumg
29=lavage
30=stool
31=swab
32=swab (skin lesion)
33=swab (nasal sinus)
34=vesicular swab
35=swab (internal nose)
36=throat swab
37=tissue
38=urine
39=vesicle fluid
40=viral isolate
41=other
42=unknown

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 AND EXPOSURE INFORMATION

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

Imported Country ___________ **Imported State** ___ **Imported County** _____________ **Imported City** _______________

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 _________ ☐

INTERNATIONAL DESTINATIONS OF RECENT TRAVEL	______________________ ______________________	**Travel Return Date** __ __ ____ (month day year)	**Length of time in the U.S since last travel:** _______________
	______________________ ______________________	**Travel Return Date** __ __ ____ (month day year)	**UNITS† LENGTH of TIME in the U.S.** __________

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

Is this case epi-linked to another confirmed or probable case? Y=yes N=no U=unknown ☐

Outbreak related? Y=yes N=no U=unknown ☐ **Outbreak Name** __________ **Investigation Start Date** __ __ ____ (month day year)

Country of Exposure _____ **State/Province of Exposure** _____ **County of Exposure** ________ **City of Exposure**________

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 ______________________________

Detection Method

- ☐ routine physical exam
- ☐ prison entry screening
- ☐ provider reported
- ☐ prenatal testing
- ☐ other ____________________
- ☐ self-referral
- ☐ unknown

Age & setting verified: does the age of the case match or make sense for the listed transmission setting? Y=yes N=no U=unknown ☐

VACCINATION HISTORY

Vaccinated (has the case-patient ever received a vaccine against this disease)? Y=yes N=no U=unknown ☐

Number of vaccine doses received on or after first birthday? 0 – 6 99 = unknown ☐☐ (doses)

Number of vaccine doses received prior to illness onset? 0–6 99=unknown ☐☐ (doses)

Date of last vaccine dose prior to illness onset: __ __ ____ (mm/dd/yyyy)

Was case-patient vaccinated as recommended by the ACIP? Y=yes N=no U=unknown ☐

Vaccine Type	Vaccination Date (month day year)	Vaccine Manuf	Vaccine Lot Number	Vaccine Expiration Date (month day year)	National Drug Code	Vaccination Record Identifier	Vaccine Event Information Source	Vaccine Dose Number
____	__ __ ____	____	________	__ __ ____	______	______	______	___
____	__ __ ____	____	________	__ __ ____	______	______	______	___
____	__ __ ____	____	________	__ __ ____	______	______	______	___
____	__ __ ____	____	________	__ __ ____	______	______	______	___

VACCINE TYPE CODES

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

VACCINE MANUFACTURER CODES

M = Merck
O = other
U = unknown

VACCINE 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/parent recall
10= historical information, patient/parent written record
UNK= unknown
OTH= other

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
17 = vaccine not available

VACCINE HISTORY COMMENTS

CASE NOTIFICATION		
Condition Code 10180	**Immediate National Notifiable Condition** Y=yes N=no U=unknown ☐	**Legacy Case ID** ________

State Case ID ______	**Local Record ID** _____	**Jurisdiction Code** ___	**Binational Reporting Criteria** ________

Date First Verbal Notification to CDC __ __ __ __ __ __ __ __ (month day year)	**Date Report First Electonically Submitted** __ __ __ __ __ __ __ __ (month day year)

Date of Electronic Case Notification to CDC -- -- -- -- -- -- -- -- (month day year)	**MMWR Week** ____	**MMWR Year** __________

Notification Result Status ☐ Final results ☐ Record coming as correction ☐ Results cannot be obtained

Person Reporting to CDC NAME __________________ (first) ______________________ (last)	**Person Reporting to CDC Email** ______________ @ ________ **Person Reporting to CDC Phone No.** (__ __ __) __ __ __ __ __ __ __
Current Occupation ____________________________	**Current Occupation Standardized** (NIOCCS code) ____________
Current Industry _______________________________	**Current Industry Standardized** (NIOCCS code) _______________

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 https://cdn.ymaws.com/www.cste.org/resource/resmgr/PS/11-ID-18.pdf