Tennessee Department of Health

Mumps Case Report

Draft, Revised: 09/2010

Please fill out all three pages of this form as complete as possible. Anything that appears in **red** is not available for data entry into NEDSS. However, you may find those fields helpful in your investigation. Do not forget to notify CEDS Immunization Program regarding this case.

DEMOGRAPHICS

CASE ID#:___________________

Last Name: ______________________ **First:** ____________________ **Middle:** ____________ **DOB:** ____/____/________

Reported Age: ________ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown

Street Address: ____

City: __________________________ **County:** ____________________________ **State:** ________ **Zip:** ___________

Phone - Home: ________________________ **Work:** _________________________ **Cell:** __________________________

Ethnicity: □ Hispanic □ Not Hispanic

Race: □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Other (______________)

Employer/School/Daycare: _____________________________________ **Occupation:** _________________________________

ALTERNATE CONTACT INFORMATION

Last Name: ___________________ **First:**__________________ **Relationship:** □ Parent □ Spouse □ Household Member □ Friend □ Other___________________

Phone #:_____________________

INVESTIGATION SUMMARY

Jurisdiction:

□ East Tennessee	□ Mid-Cumberland	□ Northeast	□ South Central	□ Southeast
□ West Tennessee	□ Upper Cumberland	□ Nashville/Davidson	□ Chattanooga/Hamilton	□ Knoxville/Knox
□ Jackson/Madison	□ Memphis/Shelby	□ Sullivan	□ Out of Tennessee	□ Unassigned

Investigation Summary

Investigation Start Date: ______/______/__________

Investigation Status: □ Open □ Closed

Investigator: ____________________________________

Date Assigned to Investigation: ______/______/_________

Physician: ______________________________________

Physician's Phone: ______________________________

Reporting Source

Date of Report: ______/______/__________

Reporting Source: _______________________________

Earliest Date Reported to County: ______/______/________

Earliest Date Reported to State: ______/______/________

Reporter: _____________________________________

CLINICAL INFORMATION

Hospital Information

Was the patient hospitalized for this illness? □ Yes □ No □ Unknown

Hospital: ____

Admission Date:____/____/_____ **Discharge Date:** ____/____/_____

Diagnosis Date: ____/____/_____ **Illness Onset Date:** ____/____/____

Age at onset?________________

Condition

Is the patient pregnant? □ Yes □ No □ Unknown

Does the patient have pelvic inflammatory disease? □ Yes □ No □ Unknown

Did the patient die from this illness? □ Yes □ No □ Unknown

Symptoms

Did patient have viral prodrome (malaise, low grade fever, body aches) before onset of parotitis? □ Yes □ No □ Unknown **If Yes, Onset date:**____/____/______

(Check all that apply)

□ **Parotitis**

Date of onset: ____/____/______

Duration (# of days): _________

□ **Fever (>100.5°F)**

Yes, highest temperature ______°F

□ **Other (______________________)**

□ **Cough**

□ **Sore Throat**

□ **Headache**

□ **Earache**

□ **Difficulty in chewing/swallowing**

□ **Sublingual (under tongue)/**

□ **Malaise**

□ **Myalgias**

□ **Arthritis/Arthalgias**

□ **Abdominal/Pelvic Pain**

Complications

(Check all that apply)

□ **Meningitis**

□ **Deafness**

□ **Orchitis**

□ **Encephalitis**

□ **Mastitis**

□ **Pancreatitis**

□ **Nephritis**

□ **Myocarditis**

□ **Arthropathy**

□ **Oophoritis**

□ **If other complications, specify**__________________

COMMENTS

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LABORATORY

CASE ID#:____________________

Was laboratory testing done for mumps? □ Yes □ No □ Unknown *(If yes, complete the table below.)*

	IgM Serum	Acute IgG Serum	Convalescent IgG Serum	Saliva Culture	Urine Culture	Other Lab Tests
Was testing performed?	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown	□ Yes □ No □ Unknown
Name of Laboratory						
Date Specimen Taken						
Result of Test	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ No significant rise in IgG □ Significant rise in IgG □ Pending □ Indeterminate □ Unknown		□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown	□ Negative □ Positive □ Pending □ Indeterminate □ Unknown

Were the clinical specimens sent to CDC for genotyping (molecular typing)? □ Yes □ No □ Unknown

Date sent for genotyping: ______/______/_________

Specimen Type:__________________________________

VACCINATION

Did the patient receive mumps containing vaccine? □ Yes □ No □ Unknown

If no, Reason:
□ Born outside of US
□ Laboratory evidence of previous disease
□ MD diagnosis of previous disease
□ Medical Contraindication
□ Parent/Patient forgot to vaccinate
□ Parent/Patient refusal
□ Parent/Patient report of disease
□ Philosophical objection
□ Religious exemption
□ Underage for vaccination
□ Unknown
□ Other (________________)

Number of doses received ON or AFTER 1st birthday: _____

Dates of each MMR vaccination: 1 ____/____/_______ 2 ____/____/_______ □ Dates Unknown

EPIDEMIOLOGIC INFORMATION

Is this patient associated with a daycare facility?: □ Yes □ No □ Unknown

***If yes*, daycare:** ________________________________

Is this case part of an outbreak?: □ Yes □ No □ Unknown

***If yes*, outbreak name:** _________________________

Where was the disease acquired?: □ Indigenous (within jurisdiction) □ Out of country □ Out of state □ Out of jurisdiction □ Unknown

Imported Country: ____________________________________ **Imported State:** ____

Imported City: ____________________________________ **Imported County:** ____

Length of time in the United States (in years): ____________ **Country of birth:** ____

What was the transmission setting (use number from choices)?__________

1 - Athletics 2 - College 3 - Community 4 - Correctional facility 5 - Day Care 6 - Doctor's office
7 - Home 8 - Hospital ER 9 - Hospital outpatient clinic 10 - Hospital ward 11 - International travel 12 - Military
13 - Church 14 - School 15 - Unknown 16 - Work 17 - Other

Were age and setting verified? □ Yes □ No □ Unknown

COMMENTS

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Epidemiologic Information (continued)

CASE ID#:____________________

Has the patient traveled out of the United States or within the United State in the past 4 weeks?

Out of US Travel?

□ Yes □ No □ Unknown

***If yes*, where:** __________________________________

Date left: ____/____/_______ **Date returned:** ____/____/_______

Did parotitis or other mumps-associated complication on-set occur within 12-25 days of entering the USA, following any travel or living outside USA? (Import Status)

□ Yes □ No □ Unknown

With in US Travel?

□ Yes □ No □ Unknown

***If yes*, where:** __________________________________

Date left: ____/____/_______ **Date returned:** ____/____/_______

If this is a U.S acquired case, how should the case be classified by source? □ Endemic case □ Import-linked case □ Imported-virus case □ Unknown source case

Is this case epi-linked to another confirmed or probable case? □ Yes □ No □ Unknown

***If yes,* name of linked case:**___________________________________

Is the source/place of mumps exposure known or suspected? □ Yes □ No □ Unknown

***If yes,* source of infection (i.e. person ID, country, etc.):**

____

Is the source affiliated with a school or college? □ Yes □ No □ Unknown

If yes: **1) Name of school or college:**_______________________________________

2) This patient's role in school (i.e. student, teacher, administrator):

____

If a student, patient's grade or year in school:_____________________

Employed in health care setting? □ Yes □ No □ Unknown

***If yes*, specify health care setting:**____ **and**

specify job category in the health care setting:____

Did the patient attend group events within the 4 weeks prior to onset of symptoms? □ Yes □ No □ Unknown

***If yes,* please describe:**____

____

Confirmation Method: □ Clinical Diagnosis □ Epidemiologically-linked □ Lab Confirmed □ Other (____________________)

Case Status: □ Confirmed □ Suspect □ Probable

Comments

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For Administrative Use Only:

Date of Interview: ____/____/_______

Interviewer's Name: _______________________________________

Other Notes: ____

Was the case entered into NEDSS? □ Yes □ No □ Unknown

Date entered into NEDSS: ____/____/_______

Data Entry Person's Name: __________________________________

CONTACT INFORMATION

Identify potentially exposed persons, household and other contacts (e.g., school/daycare classmates and contacts in the healthcare setting) through routine communicable disease interview of the case.

Index Case Name:					Index Case #:				Date of Cough Onset:
Contact Name	Date of Birth	Relationship To case	Date of exposure	# of MMR	Date of Last MMR	Is this a case?	If it's a case, Case ID#	Illness Onset Date	Parent Name (if applicable) and/or Phone Number

Comments: