

Mumps Surveillance Worksheet

NAME (Last, First)		Hospital Record No.			
Address (Street and No.)		City	County	Zip	Phone
Reporting Physician/Nurse/Hospital/Clinic/Lab Address				Phone	

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Mumps Surveillance Worksheet

County	State	Zip
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Birth Date <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	Age <input type="text"/> / <input type="text"/> <small>Unk = 999</small>	Age Type <input type="checkbox"/> 0 = 0-120 years <input type="checkbox"/> 1 = 0-11 months <input type="checkbox"/> 2 = 0-52 weeks <input type="checkbox"/> 3 = 0-28 days <input type="checkbox"/> 9 = Age unknown	Race <input type="checkbox"/> N = Native Amer./Alaskan Native <input type="checkbox"/> A = Asian/Pacific Islander <input type="checkbox"/> B = African American <input type="checkbox"/> W = White <input type="checkbox"/> O = Other <input type="checkbox"/> U = Unknown	Ethnicity <input type="checkbox"/> H = Hispanic <input type="checkbox"/> N = Not Hispanic <input type="checkbox"/> U = Unknown	Sex <input type="checkbox"/> M = Male <input type="checkbox"/> F = Female <input type="checkbox"/> U = Unknown
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Event Date <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	Event Type <input type="checkbox"/> 1 = Onset Date <input type="checkbox"/> 2 = Diagnosis Date <input type="checkbox"/> 3 = Lab Test Done <input type="checkbox"/> 4 = Reported to County <input type="checkbox"/> 5 = Reported to State or MMWR Report Date <input type="checkbox"/> 9 = Unknown	Outbreak Associated <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small> Unk = 999	Reported <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	Imported <input type="checkbox"/> 1 = Indigenous <input type="checkbox"/> 2 = International <input type="checkbox"/> 3 = Out of State <input type="checkbox"/> 9 = Unknown	Report Status <input type="checkbox"/> 1 = Confirmed <input type="checkbox"/> 2 = Probable <input type="checkbox"/> 3 = Suspect <input type="checkbox"/> 9 = Unknown
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Parotitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Meningitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Deafness? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown
Orchitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Encephalitis? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Died? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown
Notes: _____ _____ _____		
Other Complications? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown If Yes, Please Specify: _____ _____		
Hospitalized? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown		
Days Hospitalized <input type="text"/> - <input type="text"/> <small>0 - 999</small> 999 - Unknown		

Was Laboratory Testing For Mumps Done? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Vaccinated? (Received mumps-containing vaccine?) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown
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Date IGM Specimen Taken <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> I = Indeterminate <input type="checkbox"/> E = Pending <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown
Date IGG Acute Specimen Taken <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	Result <input type="checkbox"/> P = Significant Rise in IGG <input type="checkbox"/> N = No Significant Rise in IGG <input type="checkbox"/> I = Indeterminate <input type="checkbox"/> E = Pending <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown
Date IGG Convalescent Specimen Taken <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	Other Lab Result <input type="checkbox"/> P = Positive <input type="checkbox"/> N = Negative <input type="checkbox"/> I = Indeterminate <input type="checkbox"/> E = Pending <input type="checkbox"/> X = Not Done <input type="checkbox"/> U = Unknown Specify Other Lab Method: _____

Vaccination Date <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Vaccine Type</th> <th style="width: 10%;">Vaccine Manuf.</th> <th style="width: 80%;">Lot Number</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="text"/></td></tr> </tbody> </table>	Vaccine Type	Vaccine Manuf.	Lot Number	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Vaccine Type	Vaccine Manuf.	Lot Number																	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>																	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>																	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>																	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>																	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>																	
Number of doses received ON or AFTER 1st birthday <input type="text"/>																			
If Not Vaccinated, What Was The Reason? <input type="checkbox"/> <ul style="list-style-type: none"> 1 = Religious Exemption 2 = Medical Contraindication 3 = Philosophical Objection 4 = Lab. Evidence of Previous Disease 5 = MD Diagnosis of Previous Disease 6 = Under Age For Vaccination 7 = Parental Refusal 8 = Other 9 = Unknown 																			

Date First Reported to a Health Department <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>	Date Case Investigation Started <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>
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Transmission Setting (Where did this case acquire mumps?) <input type="checkbox"/> 1 = Day Care <input type="checkbox"/> 2 = School <input type="checkbox"/> 3 = Doctor's Office <input type="checkbox"/> 4 = Hospital Ward <input type="checkbox"/> 5 = Hospital ER <input type="checkbox"/> 6 = Hospital Outpatient Clinic <input type="checkbox"/> 7 = Home <input type="checkbox"/> 8 = Work <input type="checkbox"/> 9 = Unknown <input type="checkbox"/> 10 = College <input type="checkbox"/> 11 = Military <input type="checkbox"/> 12 = Correctional Facility <input type="checkbox"/> 13 = Church <input type="checkbox"/> 14 = International Travel <input type="checkbox"/> 15 = Other	Outbreak Related? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown If Yes, Outbreak Name _____
Were Age and Setting Verified? (Is age appropriate for setting, i.e. under 16 and in school, etc.) <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	Source of Exposure For Current Case Enter State ID if source was an in-state case Enter Country if source was out of USA Enter State if source was out-of-state _____
If Transmission Setting Not Among Those Listed And Known, What Was The Transmission Setting? _____	
Epi-Linked to Another Confirmed or Probable Case? <input type="checkbox"/> Y = Yes <input type="checkbox"/> N = No <input type="checkbox"/> U = Unknown	

Note: This form has 2 sides

Indicates epidemiologically important items not yet on NETSS screen

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Notes/Other Information:

Clinical Case Definition*:

An illness with acute onset of unilateral or bilateral tender, self-limited swelling of the parotid or other salivary gland, lasting ≥ 2 days, and without other apparent cause.

Case Classification*:

Probable: A case that meets the clinical case definition, has noncontributory or no serologic or virologic testing, and is not epidemiologically linked to a confirmed or probable case.

Confirmed: A case that is laboratory confirmed or that meets the clinical case definition and is epidemiologically linked to a confirmed or probable case. A laboratory-confirmed case does not need to meet the clinical case definition.

*CDC. Case Definitions for Infectious Conditions Under Public Health Surveillance. MMWR 1997;46(No. RR-10):39.