Mumps

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Investigation Information

* indicates required fields

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial

Street Address

City	County	State	Zip
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy

Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	County	State	Zip
		West Virginia	

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	Age	Age Units
		○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Patient Demographic Information cont.

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native*
☐ *Asian*
☐ *Black or African American*
☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White*
☐ *Unknown*
☐ *Failure to report race/missing race*
☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy	**Date of diagnosis** mm/dd/yyyy

Was patient hospitalized for this disease?	**Name of Hospital**	**Date of Admission** mm/dd/yyyy	**Number of days Hospitalized**
○ *Yes* ○ *No* ○ *Unknown*			

Patient outcome from this disease:	**Date of Death** mm/dd/yyyy
○ *Died* ○ *Survived* ○ *Unknown*	

Clinical Data

Parotitis	**If Yes, describe**
○ *Yes* ○ *No* ○ *Unknown*	

Complications

Meningitis	**Encephalitis**	**Orchitis**	**Deafness**
○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*	○ *Yes* ○ *No* ○ *Unknown*

Other Complications	**If Yes, specify**
○ *Yes* ○ *No* ○ *Unknown*	

Laboratory Testing

Was Laboratory Testing for Mumps Done?

○ *Yes* ○ *No* ○ *Unknown*

IgM

Collection Date mm/dd/yyyy	**Results** ○ *Positive* ○ *Negative* ○ *Pending* ○ *Indeterminate* ○ *Not Done* ○ *Unknown*

Acute:	Convalescent:
Collection Date mm/dd/yyyy	**Collection Date** mm/dd/yyyy

Result IgG

○ *Significant Rise in IgG* ○ *No Significant Rise in IgG* ○ *Indeterminate* ○ *Pending* ○ *Not Done* ○ *Unknown*

Other Lab Test

Specify Other Lab Method

Other Lab Result

○ *Positive* ○ *Negative* ○ *Indeterminate* ○ *Pending* ○ *Not Done* ○ *Unknown*

Laboratory Name	**Phone** ###-###-####	**Ext.**	**Fax Number** ###-###-####

Address

State: West Virginia	**Zip:**

Reporting Source

Last Name	**First Name**

Phone ###-###-####	**Ext.**	**Fax** ###-###-####

Facility

Address

City	**State** West Virginia	**Zip**

E-mail

Provider with Further Patient Information

Last Name	**First Name**

Phone ###-###-####	**Ext.**	**Fax** ###-###-####

Address

City	**State** West Virginia	**Zip**

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy

Investigator	Date public health investigation began mm/dd/yyyy	Health Department	Phone ###-###-####

Ext.

Investigation ID	Part of an Outbreak?	Outbreak Name	Lost to follow-up?
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

Imported

○ *Indigenous* ○ *International* ○ *Out of state* ○ *Unknown*

Vaccine Information

Received mumps containing vaccine?

○ *Yes* ○ *No* ○ *Unknown*

Number of Doses of mumps containing vaccine received ON or AFTER 1st birthday

If Not Vaccinated, What Was The Reason?

○ *Religious Exemption* ○ *Medical Contraindication* ○ *Philosophical Exemption*
○ *Lab Evidence of Previous Disease* ○ *MD Diagnosis of Previous Disease* ○ *Under Age For Vaccination*
○ *Parental Refusal* ○ *Unknown* ○ *Other (specify)*_____

Vaccination Date	Vaccine Type	Vaccine Manufacturer	Lot Number
mm/dd/yyyy	A=MMR B=Mumps O=Other U=Unknown	M=Merck O=Other U=Unknown	

Epidemiologic Information

Transmission Setting
(Where did this case acquire mumps?)

○ *Daycare* ○ *School* ○ *Doctor's Office* ○ *Hospital Ward* ○ *Hospital ER*
○ *Hospital Outpatient Clinic* ○ *Home* ○ *Work* ○ *Unknown* ○ *College*
○ *Military* ○ *Correctional Facility* ○ *Church* ○ *International Travel* ○ *Other*_____

Were Age and Setting Verified?
(Is age appropriate for setting, i.e. aged 49 years and in day care, etc.)

○ *Yes* ○ *No* ○ *Unknown*

Epi-Linked to Another Confirmed or Probable Case?

○ *Yes* ○ *No* ○ *Unknown*

Source of Exposure For Current Case
(Enter State ID if source was an in-state case; Enter State if source was out-of-state; Enter Country if source was out of US.)

Describe public health action taken