



# Mumps

County \_\_\_\_\_

Case name (last, first) \_\_\_\_\_  
 Birth date \_\_\_/\_\_\_/\_\_\_ Sex at birth  F  M  Other Alternate name \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Address type  Home  Mailing  Other  Temporary  Work  
 Street address \_\_\_\_\_  
 City/State/Zip/County \_\_\_\_\_  
 Residence type (incl. Homeless) \_\_\_\_\_ WA resident  Yes  No

## ADMINISTRATIVE

**Investigator** \_\_\_\_\_  
 LHJ Case ID (optional) \_\_\_\_\_  
**LHJ notification date** \_\_\_/\_\_\_/\_\_\_  
**Classification**  Classification pending  Confirmed  
 Not reportable  Probable  Ruled out  Suspect  
 Investigation status  
 In progress  
 Complete  
 Complete – not reportable to DOH  
 Unable to complete Reason \_\_\_\_\_  
**Investigation start date** \_\_\_/\_\_\_/\_\_\_  
 Investigation complete date \_\_\_/\_\_\_/\_\_\_  
**Case complete date** \_\_\_/\_\_\_/\_\_\_  
 Outbreak related  Yes  No  
 LHJ Cluster ID \_\_\_\_\_ Cluster Name \_\_\_\_\_

## DEMOGRAPHICS

Age at symptom onset \_\_\_\_\_  Years  Months  
**Ethnicity**  Hispanic or Latino  Not Hispanic or Latino  Unk  
**Race** (check all that apply)  Unk  Amer Ind/AK Native  
 Asian  Black/African Amer  Native HI/other PI  
 White  Other \_\_\_\_\_  
 Primary language \_\_\_\_\_  
 Interpreter needed  Yes  No  Unk  
 Employed  Yes  No  Unk Occupation \_\_\_\_\_  
 Industry \_\_\_\_\_ Employer \_\_\_\_\_  
 Work site \_\_\_\_\_ City \_\_\_\_\_  
 Student/Day care  Yes  No  Unk  
 Type of school  Preschool/day care  K-12  College  
 Graduate School  Vocational  Online  Other  
 School name \_\_\_\_\_  
 School address \_\_\_\_\_  
 City/State/County \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone number \_\_\_\_\_ Teacher's name \_\_\_\_\_

## REPORT SOURCE

**Initial report source** \_\_\_\_\_  
 LHJ \_\_\_\_\_  
 Reporter organization \_\_\_\_\_  
 Reporter name \_\_\_\_\_  
 Reporter phone \_\_\_\_\_  
 All reporting sources (list all that apply)  
 \_\_\_\_\_  
 \_\_\_\_\_

## COMMUNICATIONS

Primary HCP name \_\_\_\_\_  
 Phone \_\_\_\_\_  
 OK to talk to patient (If Later, provide date)  
 Yes  Later \_\_\_/\_\_\_/\_\_\_  Never  
 Date of interview attempt \_\_\_/\_\_\_/\_\_\_  
 Complete  Partial  Unable to reach  
 Patient could not be interviewed  
 Alternate contact  Parent/Guardian  Spouse/Partner  
 Friend  Other \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

## CLINICAL INFORMATION

Complainant ill  Yes  No  Unk Symptom Onset \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date \_\_\_/\_\_\_/\_\_\_  
 Illness duration \_\_\_\_\_  Days  Weeks  Months  Years Illness is still ongoing  Yes  No  Unk

### Clinical Features

**Y N Unk**  
   Any fever, subjective or measured Temp measured?  Yes  No Highest measured temp \_\_\_\_\_ °F  
 Fever duration \_\_\_\_\_ days Fever onset date \_\_\_/\_\_\_/\_\_\_  
   **Parotitis or other salivary gland swelling** Onset date \_\_\_/\_\_\_/\_\_\_ End date \_\_\_/\_\_\_/\_\_\_  
   **Did parotitis or other salivary gland swelling last at least 2 days**  
   **Orchitis unexplained by another more likely diagnosis** Onset date \_\_\_/\_\_\_/\_\_\_  
   **Oophoritis unexplained by another more likely diagnosis** Onset date \_\_\_/\_\_\_/\_\_\_  
   Hearing loss Onset date \_\_\_/\_\_\_/\_\_\_  
   Mastitis Onset date \_\_\_/\_\_\_/\_\_\_  
   Pancreatitis Onset date \_\_\_/\_\_\_/\_\_\_  
   Meningitis Onset date \_\_\_/\_\_\_/\_\_\_  
   Encephalitis Onset date \_\_\_/\_\_\_/\_\_\_  
   MMR vaccination within 45 days preceding onset  
   Any other complication \_\_\_\_\_

**Vaccination**

**Y N Unk**

Ever received mumps containing vaccine Number of mumps doses prior to illness \_\_\_\_\_  
 Number of doses before the 1<sup>st</sup> birthday \_\_\_\_\_  
 Number of doses on or after 1<sup>st</sup> birthday \_\_\_\_\_

Vaccine information available  Yes  No

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_

Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_

Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_

Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

Date of vaccine administration \_\_\_/\_\_\_/\_\_\_ Vaccine administered (Type) \_\_\_\_\_

Vaccine lot number \_\_\_\_\_ Administering provider \_\_\_\_\_

Information source  Washington Immunization Information System (WIIS) WIIS ID number \_\_\_\_\_

Medical record  Patient vaccination card  Verbal only/no documentation  Other state IIS

**Y N Unk**

Mumps vaccination up to date for age per ACIP

Vaccine series not up to date reason

Religious exemption  Medical contraindication  Philosophical exemption

Laboratory confirmation of previous disease  MD diagnosis of previous disease

Underage for vaccine  Parental refusal  Other  Unknown

**Hospitalization**

**Y N Unk**

Hospitalized at least overnight for this illness Facility name \_\_\_\_\_

Hospital admission date \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_ HRN \_\_\_\_\_

Admitted to ICU Date admitted to ICU \_\_\_/\_\_\_/\_\_\_ Date discharged from ICU \_\_\_/\_\_\_/\_\_\_

Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

**Y N Unk**

Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ *Please fill in the death date information on the Person Screen*

Autopsy performed

Death certificate lists disease as a cause of death or a significant contributing condition

Location of death  Outside of hospital (e.g., home or in transit to the hospital)  Emergency department (ED)

Inpatient ward  ICU  Other

**RISK AND RESPONSE (Ask about exposures 12-25 days before symptom onset)**

**Travel**

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

**Risk and Exposure Information**

**Y N Unk**

Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country \_\_\_\_\_

Contact with recent foreign arrival Country \_\_\_\_\_ Date(s) of contact \_\_\_/\_\_\_/\_\_\_

Congregate living

Barracks  Corrections  Long term care  Dormitory  Boarding school  Camp  Shelter

Other \_\_\_\_\_

**Exposure and Transmission Summary**

**Y N Unk**

Epi-linked to a confirmed or probable case

Outbreak related

Likely geographic region of exposure  In Washington – county \_\_\_\_\_  Other state \_\_\_\_\_

Not in US - country \_\_\_\_\_  Unk

International travel related  During entire exposure period  During part of exposure period  No international travel

Suspected exposure type  Person to person  Health care associated  Unk  Other \_\_\_\_\_

Describe \_\_\_\_\_

- Suspected exposure setting  Day care/Childcare  School (not college)  Doctor's office  Hospital ward  Hospital ER  
 Hospital outpatient facility  Home  Work  College  Military  Correctional facility  Place of worship  
 Laboratory  Long term care facility  Homeless/shelter  International travel  Out of state travel  Transit  
 Social event  Large public gathering  Restaurant  Hotel/motel/hostel  Other \_\_\_\_\_

Describe \_\_\_\_\_

Exposure Summary

- Suspected transmission type (check all that apply)  Person to person  Health care associated  Unk  
 Other \_\_\_\_\_

Describe \_\_\_\_\_

- Suspected transmission setting (check all that apply)  Day care/Childcare  School (not college)  Doctor's office  
 Hospital ward  Hospital ER  Hospital outpatient facility  Home  Work  College  Military  
 Correctional facility  Place of worship  Laboratory  Long term care facility  Homeless/shelter  
 International travel  Out of state travel  Transit  Social event  Large public gathering  Restaurant  
 Hotel/motel/hostel  Other \_\_\_\_\_

Describe \_\_\_\_\_

**Public Health Issues**

- Evaluated immune status of close contacts**  Yes Date initiated \_\_\_/\_\_\_/\_\_\_  
 Number of close contacts evaluated for immune status \_\_\_\_\_  
 Number of susceptible contacts identified \_\_\_\_\_  
 No, close contacts not evaluated  
 No, case had no close contacts  
 Unk

*If needed, enter detailed information in the Transmission Tracking Question Package*

**Public Health Interventions/Actions**

- Y N Unk**  
   Recommend droplet isolation if in a health care setting  
   Isolate and exclude case from work, school, and all public places  
   Exclude exposed susceptible persons from work/school for incubation period  
   Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_

**TRANSMISSION TRACKING**

**Contact investigation period: 2 days prior to parotitis onset, 5 days after parotitis onset**

Visited, attended, employed, or volunteered at any public settings while contagious  Yes  No  Unk

Settings and details (check all that apply)

- Day care  School  Airport  Hotel/Motel/Hostel  Transit  Health care  Home  Work  College  
 Military  Correctional facility  Place of worship  International travel  Out of state travel  LTCF  
 Homeless/shelter  Social event  Large public gathering  Restaurant  Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

*If list of contacts is known, please fill out Contact Tracing Form Question Package*

**TREATMENT**Did patient receive prophylaxis/treatment  Yes  No  UnkSpecify medication \_\_\_\_\_  Antibiotic  Antiviral  Other \_\_\_\_\_

Number of days actually taken \_\_\_\_\_ Treatment start date \_\_\_/\_\_\_/\_\_\_ Treatment end date \_\_\_/\_\_\_/\_\_\_

**NOTES****LAB RESULTS****Lab report information**Lab report information**Lab report reviewed – LHJ** 

WDRS user-entered lab report note \_\_\_\_\_

Submitter \_\_\_\_\_

Performing lab for entire report \_\_\_\_\_

Referring lab \_\_\_\_\_

Specimen**Specimen identifier/accession number** \_\_\_\_\_**Specimen collection date** \_\_\_/\_\_\_/\_\_\_ **Specimen received date** \_\_\_/\_\_\_/\_\_\_**WDRS specimen type** \_\_\_\_\_

WDRS specimen source site \_\_\_\_\_

WDRS specimen reject reason \_\_\_\_\_

Test performed and result**WDRS test performed** \_\_\_\_\_**WDRS test result, coded** \_\_\_\_\_

WDRS test result, comparator \_\_\_\_\_

**WDRS result, numeric only** (enter only if given, including as necessary **Comparator** and **Unit of measure**) \_\_\_\_\_

WDRS unit of measure \_\_\_\_\_

Test method \_\_\_\_\_

WDRS interpretation code \_\_\_\_\_

Test result – Other, specify \_\_\_\_\_

**WDRS result summary**  Positive  Negative  Indeterminate  Equivocal  Test not performed  PendingTest result status  Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date \_\_\_/\_\_\_/\_\_\_

**Upload document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_