

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

MUMPS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 28

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name First Middle Suffix Maiden/Other Alias Birthdate (mm/dd/yyyy) SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Was testing for mumps done?
Date IgM specimen taken IgM result
Date IgG acute specimen taken IgG result
Date IgG convalescent specimen taken IgG result
Specify other laboratory methods and results Other results

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic?
Fever
Swollen lymph nodes (lymphadenopathy or lymphadenitis)
Headache
Stiff neck
Eyes sensitive to light (photophobia)
Thrombocytopenia
Meningitis
Encephalitis
Arthritis
Parotitis
Salivary gland involvement?
Can the patient be epidemiologically linked to anyone with the following clinically compatible illnesses?
Restrictions to movement or freedom of action?
TRAVEL
Did patient have a travel history during the 25 days prior to onset of symptoms until 5 days after onset of swelling?

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE (CONTINUED)

Reason(s) for travel:

Vacation / tourism Airline / Ship crew
 Organized tour Missionary or dependent

Business related, specify _____
 Refugee / Immigrant

Military related Student / Teacher
 Visit to family / friends Unknown
 Peace corps Other _____

Mode(s) of transportation (check all that apply)

Airplane
 Ship / boat / ferry
 Cruise ship? Y N U
 Specify cruise line _____
 Train / subway
 On foot
 Bus/taxi/shuttle
 Automobile / motorcycle
 Other, specify: _____

To country: _____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

List person(s): _____

Does the patient know anyone else with similar symptoms? Y N U

If yes, list name(s) and relationship to person(s): _____

Is the patient part of an outbreak of this disease? Y N

VACCINE

Has patient/contact ever received mumps-containing vaccine? Y N U

If yes, date of vaccination #1
(mm/dd/yyyy) _____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____

If yes, date of vaccination #2
(mm/dd/yyyy) _____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____

Vaccine date unknown Y N

If no, reason for inadequate vaccination:

Religious exemption
 Medical exemption
 Medical contraindication
 Philosophical exemption (outside NC only)
 Laboratory evidence of previous disease
 Physician diagnosis of previous disease
 Under age for vaccination
 Parental refusal
 Missed opportunities
 Unknown
 Other, specify: _____

(CONTINUED)

Source of vaccine information:

Patient's or Parent's verbal report
 Physician*
 Medical record*
 Certificate of immunization record*
 Patient vaccine record*
 School record
 Other, specify: _____
 NCIR record
 Unknown

If yes, number of doses received on or after first birthday: _____

CLINICAL FINDINGS

Was the mother of this infant/child case diagnosed with this disease? Y N U

If yes:
Date of diagnosis (mm/dd/yyyy): _____
Time frame of diagnosis:
 Prior to pregnancy
 During pregnancy
 At delivery
 After delivery
 Before birth - exact period unknown
 Time frame unknown

If no:
Was mother known not to have disease after the birth of this child? Y N U

REASON FOR TESTING

Why was the patient tested for this condition?

Symptomatic of disease
 Screening of asymptomatic person with reported risk factor(s)
 Exposed to organism causing this disease (asymptomatic)
 Household / close contact to a person reported with this disease
 Other, specify _____
 Unknown

MATERNAL INFORMATION

Date of birth of biologic mother
(mm/dd/yyyy): _____

If date of birth is unknown, provide biologic mother's age in years: _____

Was the biologic mother born outside the US? Y N U

If yes, country: _____

Date of biologic mother's arrival in the US
(mm/dd/yyyy): _____

Did the biologic mother ever have evidence of serological IgG immunity? Y N U

Test date (mm/dd/yyyy): _____

Result:
 Positive
 Negative
 Equivocal
 Unknown

Was the child's biologic mother immunized with vaccine against this specific disease? Y N U

Type of vaccine:
 Measles
 Mumps
 Rubella

Vaccine date (mm/dd/yyyy): _____

Source of vaccine information:
 Patient's or Parent's verbal report
 Physician
 Medical record
 Certificate of immunization record
 Patient vaccine record
 School record
 Other
 Unknown

PREGNANCY

Is the patient currently pregnant? ... Y N U

Estimated delivery date (mm/dd/yyyy): _____

Give number of weeks gestation at onset of illness: _____

Did patient have prenatal care? Y N U

Setting of prenatal care
 Public sector
 Private sector
 Unknown

Prenatal provider name: _____

Did patient attend family planning clinic prior to conception? Y N U

Has the patient ever been pregnant? Y N U

Total number of previous pregnancies by the biologic mother _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U
Specify _____

Autoimmune disease Y N U
Specify _____

Other underlying illness Y N U
Please specify: _____

Was the patient receiving any of the following treatments or taking any medications?

Antibiotics Y N U
For what medical condition? _____

Chemotherapy Y N U
If yes, was therapy within the last 30 days before this illness? Y N U
For what medical condition? _____

Radiotherapy Y N U
If yes, was therapy within the last 30 days before this illness? Y N U
For what medical condition? _____

Systemic steroids/corticosteroids, including steroids taken by mouth or injection Y N U
If yes, was medication taken within the last 30 days before this illness? Y N U
For what medical condition? _____

Immunosuppressive therapy, including anti-rejection therapy Y N U
If yes, specify: _____
If yes, was medication taken within the last 30 days before this illness? Y N U
For what medical condition? _____

Aspirin or aspirin-containing product Y N U
If yes, was medication taken within the last 30 days before this illness? Y N U
For what medical condition? _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Patient died in North Carolina? Y N U

County of death: _____

Died outside NC? Y N U
Specify where: _____

Autopsy performed? Y N U
Facility where autopsy was performed: _____

Patient autopsied in NC? Y N U
County of autopsy: _____

Autopsied outside NC, specify where: _____

Source of death information (select all that apply):
Note: The death certificate, autopsy report, hospital/physician discharge summary, and/or other documentation should be attached to this event.

Death certificate
 Autopsy report final conclusions
 Hospital/physician discharge summary
 Other: _____

Cause of death: _____

Death date (mm/dd/yyyy): _____

TRAVEL/IMMIGRATION

The patient is:

Resident North Carolina
 Resident of another state or US territory
 Foreign visitor
 Refugee

Refugee camp(s)? Y N U
Name of camp _____
Location of camp _____
Country of birth _____
Last country prior to arrival in US _____
Date of entry to US _____

Recent immigrant
Country of birth _____
Last country prior to arrival in US _____
Date of entry to US _____

Foreign adoptee
Country of birth _____
Last country prior to arrival in US _____
Date of entry to US _____

None of the above

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) Y N
If yes, specify: _____

Were written isolation orders issued? Y N
If yes, where was the patient isolated? _____
Date isolation started? _____
Date isolation ended? _____
Was the patient compliant with isolation? Y N

Were written quarantine orders issued? Y N
If yes, where was the patient quarantined? _____
Date quarantine started? _____
Date quarantine ended? _____
Was the patient compliant with quarantine? Y N

Notes: _____

TREATMENT

Did patient take an antibiotic as treatment for this illness? Y N U
If yes, specify antibiotic name: _____
Dose _____
Date antibiotic began (mm/dd/yyyy): _____
Date antibiotic ended (mm/dd/yyyy): _____
Number of days taken: _____ Unknown

Has the patient ever received immune globulin? Y N U
When was the last dose received? (mm/dd/yyyy): _____

Did the patient receive medical care for this illness? Y N U
Specify level(s) of care (check all that apply):
 Outpatient
 Emergency department
 Inpatient
 ICU
 Other: _____
 Unknown

Did patient have contact with a person with travel history during the period of interest? Y N U

Contact's name: _____
Travel dates: From: _____ until _____
To city: _____
To state: _____
To country: _____

Is contact a:
 Resident of another state or US territory
 Foreign visitor
 Recent immigrant
 Refugee
 Foreign adoptee
 Unknown
 Other, specify: _____

Notes: _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
Name of care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____

Patient a child care worker or volunteer in child care? Y N U
Name of child care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____

Patient a parent or primary caregiver of a child in child care? Y N U
Name of child care provider: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____

Is patient a student? Y N U
Type of school:
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Contact name: _____
Telephone: (_____) _____
Specify grade: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U
Type of school:
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City: _____ State: _____
Zip code: _____ County: _____
Telephone: (_____) _____

Notes: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy)
						SSN

BEHAVIORAL RISK & CONGREGATE LIVING

During the 25 days prior to onset of symptoms until 5 days after onset of swelling did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U
 Name of facility: _____
 Dates of contact: _____

During the 25 days prior to onset of symptoms until 5 days after onset of swelling, did the patient attend social gatherings or crowded settings? Y N U
 If yes, specify: _____

In what setting was the patient most likely exposed?

- | | |
|--|--|
| <input type="checkbox"/> Restaurant | <input type="checkbox"/> Place of Worship |
| <input type="checkbox"/> Home | <input type="checkbox"/> Outdoors, including woods or wilderness |
| <input type="checkbox"/> Work | <input type="checkbox"/> Athletics |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Farm |
| <input type="checkbox"/> School | <input type="checkbox"/> Pool or spa |
| <input type="checkbox"/> University/College | <input type="checkbox"/> Pond, lake, river or other body of water |
| <input type="checkbox"/> Camp | <input type="checkbox"/> Hotel / motel |
| <input type="checkbox"/> Doctor's office/ Outpatient clinic | <input type="checkbox"/> Social gathering, other than listed above |
| <input type="checkbox"/> Hospital In-patient | <input type="checkbox"/> Travel conveyance (airplane, ship, etc.) |
| <input type="checkbox"/> Hospital Emergency Department | <input type="checkbox"/> International |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Community |
| <input type="checkbox"/> Long-term care facility / Rest Home | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Military | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Prison/Jail/Detention Center | |

Does the patient have any other risk factors for this disease? Y N U
 Specify: _____

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

- Specify location:
- In NC
 City _____
 County _____
- Outside NC, but within US
 City _____
 State _____
 County _____
- Outside US
 City _____
 Country _____
- Unknown

Notes:

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 25 days prior to onset of symptoms until 5 days after onset of swelling, did the patient have any of the following health care exposures?
 Emergency Dept. (not hospitalized)... Y N U

Visit/admit date (mm/dd/yyyy): _____
 Facility name _____
 City _____ State _____
 Country _____
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): _____

Hospital Y N U
 Visit/admit date (mm/dd/yyyy): _____
 Facility name _____
 City _____ State _____
 Country _____
 Has patient been discharged? Y N U
 Discharge date (mm/dd/yyyy): _____
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): _____

LTC facility—resident Y N U
 Visit/admit date (mm/dd/yyyy): _____
 Facility name _____
 City _____ State _____
 Country _____
 Has patient been discharged? Y N U
 Discharge date (mm/dd/yyyy): _____
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): _____

Outpatient facility—patient Y N U
 Visit date (mm/dd/yyyy): _____
 Facility name _____
 City _____ State _____
 Country _____
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): _____

Visitor to health care setting Y N U
 Visit date (mm/dd/yyyy): _____
 Until date (mm/dd/yyyy): _____
 Frequency:
 Once
 Multiple times within this time period
 Daily
 Facility name _____
 City _____ State _____
 Country _____
 Was facility notified regarding ill patient?
 Yes No Unknown Not applicable
 Name of person notified _____
 Date notified (mm/dd/yyyy): _____

Worked or volunteered in health care or clinical setting Y N U
 Facility name _____
 City _____ State _____
 Country _____

Occupation:
 Physician
 Physician's assistant or nurse practitioner
 Nurse
 Laboratory
 Other
 Unknown
 Specify work setting or volunteer duties: _____

Was facility notified regarding ill patient?
 Yes No Unknown N/A
 Name of person notified _____
 Date notified (mm/dd/yyyy): _____

Other, specify _____

Was patient employed in a laboratory? Y N U
 If yes, specify and give details: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
 Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U
 Who was interviewed? _____

Were health care providers consulted? Y N U
 Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
 Specify reason if medical records were not reviewed: _____

Notes on medical record verification:

Mumps

2008 CDC Case Definition

Clinical case definition

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

Clinically Compatible Illness

Infection with mumps virus may present as aseptic meningitis, encephalitis, hearing loss, orchitis, oophoritis, parotitis or other salivary gland swelling, mastitis or pancreatitis.

Laboratory criteria

- Isolation of mumps virus from clinical specimen, or
- Detection of mumps nucleic acid (e.g., standard or real time RT-PCR assays), or
- Detection of mumps IgM antibody, or
- Demonstration of specific mumps antibody response in absence of recent vaccination, either a four-fold increase in IgG titer as measured by quantitative assays, or a seroconversion from negative to positive using a standard serologic assay of paired acute and convalescent serum specimens.

Case Classification

Suspected: A case with clinically compatible illness or that meets the clinical case definition without laboratory testing, or a case with laboratory tests suggestive of mumps without clinical information.

Probable: A case that meets the clinical case definition without laboratory confirmation and is epidemiologically linked to a clinically compatible case.

Confirmed: A case that: 1) meets the clinical case definition or has clinically compatible illness, and 2) is either laboratory confirmed or is epidemiologically linked to a confirmed case.