



Mumps Case Track Record	FINAL STATUS: <input type="checkbox"/> CONFIRMED <input type="checkbox"/> PROBABLE <input type="checkbox"/> RULED OUT /NOT A CASE	NBS PATIENT ID#: _____
Patient's Name: _____ last _____ first Address: _____ City: _____ County: _____ Zip: _____ Region: _____ Phone: () _____ Parent/Guardian: _____ Physician: _____ Phone: () _____ Address: _____	Reported By: _____ Agency: _____ Phone: () _____ Date: ____/____/____ Report Given to: _____ Organization: _____ Phone: () _____	
DEMOGRAPHICS: DATE OF BIRTH: ____/____/____ AGE: _____ SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown RACE: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ HISPANIC: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
CLINICAL DATA: DATE OF ONSET: ____/____/____ <input type="checkbox"/> Parotitis - Onset Date: ____/____/____ Parotitis Duration: _____ Days COMPLICATIONS: <input type="checkbox"/> Meningitis <input type="checkbox"/> Deafness <input type="checkbox"/> Orchitis <input type="checkbox"/> Encephalitis <input type="checkbox"/> Death <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hospitalized at: _____ Admitted: ____/____/____ Discharged: ____/____/____ # Days _____		
LABORATORY DATA: Was laboratory testing done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown LABORATORY: <input type="checkbox"/> DSHS <input type="checkbox"/> Other: _____ Phone: () _____ <input type="checkbox"/> PCR: Date specimen collected: ____/____/____ Result: _____ <input type="checkbox"/> IgM: Date specimen collected: ____/____/____ Result: _____ <input type="checkbox"/> IgG: Date acute collected: ____/____/____ Result: _____ Date convalescent collected: ____/____/____ Result: _____ <input type="checkbox"/> Mumps Virus Isolated: Type of specimen: _____ Date specimen collected: ____/____/____		
VACCINATION HISTORY: CDC Objective: 90% of mumps cases must have a vaccination history captured. VACCINATED: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, list dates: <input type="checkbox"/> 1 MMR: ____/____/____ <input type="checkbox"/> 2 MMR: ____/____/____ If no, indicate reason: <input type="checkbox"/> Religious exemption <input type="checkbox"/> Medical Contraindication <input type="checkbox"/> Evidence of immunity <input type="checkbox"/> Previous Disease - Lab Confirmed <input type="checkbox"/> Previous Disease - MD Diagnosed <input type="checkbox"/> Under Age <input type="checkbox"/> Parental Refusal <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		
INFECTION TIMELINE: Enter onset of parotitis. Count backwards and forwards to enter dates for probable exposure and communicable periods.		
<p style="font-size: small;"> Probable Exposure: A solid horizontal line with vertical end caps above the axis, spanning from approximately -25 days to -7 days. Period of Communicability: A dashed horizontal line with vertical end caps above the axis, spanning from approximately -7 days to +5 days. The axis has vertical tick marks every day. Labeled points are: -25 Days, -12 Days, -7 Days, -2 Days, Parotitis Onset, +5 Days. </p>		

Name: _____

- SOURCE OF INFECTION:** No exposure identified Close contact with a known or suspected case: _____
- Where did this case acquire mumps?: Day-care School College Work Home Dr. Office Hospital ER Hospital Inpatient Hospital Outpatient Military Jail Church International Travel Unknown Other: _____
 - Has any travel occurred within the exposure period? Yes No Unknown If yes, list location: _____
 - Importation Class*: Indigenous International Out-of-state Unknown If imported, from what country/state: _____
 - Is case traceable within 2 generations to international import? Yes No Unknown
 - Is case part of an outbreak?: Yes No Unknown If yes, list outbreak name: _____

*<http://wwwn.cdc.gov/NNDSS/beta/bcasedef.aspx?CondYrID=783&DatePub=1/1/2012>

HOUSEHOLD CONTACTS: Were Control Activities Initiated?: Yes No Unknown If no, explain: _____

Name	Relation to Case	Age	Mumps Disease History	Mumps Vaccine History
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown

POSSIBLE SPREAD CONTACTS:

Name	Relation to Case	Age	Mumps Disease History	Mumps Vaccine History
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown
_____	_____	_____	<input type="checkbox"/> Yes-_____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> 2 MMR <input type="checkbox"/> 1 MMR <input type="checkbox"/> None <input type="checkbox"/> Unknown

CDC Objective: 90% of vaccine preventable cases must be investigated and reported to the CDC within 30 days of initial report.

Date Investigation Initiated: ____/____/____ Date Investigation Completed: ____/____/____ Date Reported to DSHS: ____/____/____

Investigator's Name: _____ Agency name: _____ Phone :(_____) _____

Closed in NBS? Yes No

If confirmed or probable, notification submitted? Yes No

COMMENTS: