New Jersey Department of Health
Vaccine Preventable Diseases Program
PO Box 369
Trenton, NJ 08625-0369

Case Status
☐ Confirmed
☐ Probable
☐ Not a Case

MUMPS SURVEILLANCE WORKSHEET

Patient Name (Last, First)	Telephone No.	CDRSS #	E#
Street Address	City	Zip	County

Reporting Source	Treating Physician	Address of Physician	Telephone No.
Dates Physician Saw	Name of Investigator	Name of Agency	Telephone No.
Hospital	Hospital Record Number	Hospital Address	Telephone No.

Birth Date
__ __ / __ __ / __ __
(mm/dd/yy)

Age
__ __ __
(Unknown = 999)

Age Type
0 ☐ 0-120 Years
1 ☐ 0-11 Months
2 ☐ 0-2 Weeks
3 ☐ 0-28 Days
9 ☐ Age Unknown

Ethnicity
H ☐ Hispanic
N ☐ Not Hispanic
U ☐ Unknown

Race
N ☐ Native American/Alaskan Native
A ☐ Asian/Pacific Islander
B ☐ African American
W ☐ White
O ☐ Other
U ☐ Unknown

Sex
M ☐ Male
F ☐ Female
U ☐ Unknown

Event Date
__ __ / __ __ / __ __
(mm/dd/yy)

Event Type
1 ☐ Onset Date
2 ☐ Diagnosis Type
3 ☐ Lab Test Date
4 ☐ Reported to County
5 ☐ Reported to State or MMWR Report Date
9 ☐ Unknown

Outbreak Associated
__ __ __
(Unknown = 999)

Reported
__ __ / __ __ / __ __
(mm/dd/yy)

Imported
1 ☐ Indigenous
2 ☐ International
3 ☐ Out of State
9 ☐ Unknown

CLINICAL DATA

Clinical Profile				Course of Disease							
Symptoms	Y	N	U	Date of Onset	Duration of Symptoms (Days) 1	2	3	4	5	6	7
Fever (Max. ________ ° F)											
Bilateral Parotid Swelling											
Unilateral Parotid Swelling											
Parotid Tenderness											
Malaise											
Earache				//////////////							
Pain in Jaw (Chewing/Eating)				//////////////							
Arthralgia				//////////////							
Other (specify):											
Headache											

COMPLICATIONS

Symptoms	Y	N	U
Meningitis			
Deafness			
Orchitis			
Encephalitis			
Death			
Other Complications (If Yes, specify):			
Hospitalized? (If Yes, Days Hospitalized): __ __ __ *(0-998; 999 – Unknown)*			

LABORATORY

Was Laboratory Testing for Mumps Done?
☐ Yes ☐ No ☐ Unknown

Date IgM Specimen Taken
__ __ / __ __ / __ __
(mm/dd/yy)

Result
P ☐ Positive
E ☐ Pending
N ☐ Negative
X ☐ Not Done
I ☐ Indeterminate
U ☐ Unknown

Date IgG Acute Specimen Taken
__ __ / __ __ / __ __
(mm/dd/yy)

Date IgG Convalescent Specimen Taken
__ __ / __ __ / __ __
(mm/dd/yy)

Result
P ☐ Significant Rise in IgG
N ☐ No Significant Rise in IgG
I ☐ Indeterminate
X ☐ Not Done
E ☐ Pending
U ☐ Unknown

Other Lab Result
P ☐ Positive
N ☐ Negative
I ☐ Indeterminate
X ☐ Not Done
E ☐ Pending
U ☐ Unknown

Specify Other Lab Method

MUMPS SURVEILLANCE WORKSHEET, Continued

VACCINE HISTORY

Vaccinated? (Received mumps-containing vaccine?)
- ☐ Yes
- ☐ No
- ☐ Unknown

Number of doses received ON or AFTER 1st birthday:

If not vaccinated, what was the reason?
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

Vaccination Date ***(MM/DD/YY)***	**Vaccine**	**Vaccine Type Code** **(A=MMR, B=Mumps, O=Other, U=Unknown)**	**Vaccine Manuf. Code** **(M=Merck, O=Other, U=Unknown)**	**Lot Number**

EPIDEMIOLOGIC

Date First Reported to a Health Dept.
__ __ / __ __ / __ __
(mm/dd/yy)

Date Case Investigation Started
__ __ / __ __ / __ __
(mm/dd/yy)

Outbreak Related?
- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, Outbreak Name

Transmission Setting (Where did this case acquire mumps?)
1 ☐ Day Care
2 ☐ School
3 ☐ Doctor's Office
4 ☐ Hospital Ward
5 ☐ Hospital ER
6 ☐ Hospital Outpatient Clinic
7 ☐ Home
8 ☐ Work
9 ☐ Unknown
10 ☐ College
11 ☐ Military
12 ☐ Correctional Facility
13 ☐ Church
14 ☐ International Travel
15 ☐ Other

If Other, specify Transmission Setting:

Were Age and Setting Verified? (Is age appropriate for setting, i.e., aged 49 years and in day care, etc.?
☐ Yes ☐ No ☐ Unknown

Source of Exposure for Current Case:

Epi-Linked to Another Confirmed or Probable Case?
☐ Yes ☐ No ☐ Unknown

STATE USE ONLY!	Date Surveillance Rec'd at State __ __ / __ __ / __ __ *(mm/dd/yy)*	Date Reviewed at State __ __ / __ __ / __ __ *(mm/dd/yy)*	Date Sent to CDC. __ __ / __ __ / __ __ *(mm/dd/yy)*

CONTACT INFORMATION

Primary Contacts	**Relationship To Patient**	**Exposure Date**	**Date of Birth**	**Sex**	**Telephone Number**	**Name of School/Work**	**Re-cent Ill.**	**Vacc**	**Dis.**

Clinical Case Definition (1999):
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 (1999):
Probable: a case that meets the clinical case definition, has non-contributory 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.