Utah Department of Health
P.O. Box 142104
288 North 1460 West
Salt Lake City, UT 84114-2104
Phone (801) 538 - 6191
Fax (801) 538 - 9923

# MUMPS INVESTIGATION FORM

Please fill in the blanks or check the answer for each question.

Print Form

## PATIENT INFORMATION/DEMOGRAPHICS

Last Name _____ First Name _____

Street Address _____ Date of Birth _____ Age _____

City _____ Phone number _____

Zip Code _____ County _____ Date Reported _____

Gender _____ Race ☐ White ☐ Black/Af. Am ☐ Native Am. ☐ Unknown ☐ Asian ☐ Pacific Islander ☐ Native Alask.

Ethnicity ☐ Hispanic ☐ Not Hispanic ☐ Other ☐ Unknown

Current school/college/worksite _____

List any congregate living (i.e. dorm, correctional facility, etc.) _____

## CLINICAL INFORMATION

Onset Date _____ Hospital _____ Hospitalized ☐ Yes ☐ No ☐ Unknown

Doctor Name _____ Phone # _____ Did patient die? ☐ Yes ☐ No ☐ Unknown

| | Yes | No | Unknown |
|---|---|---|---|
| Orchitis | ☐ | ☐ | ☐ |
| Deafness | ☐ | ☐ | ☐ |
| Encephalitis | ☐ | ☐ | ☐ |
| Meningitis | ☐ | ☐ | ☐ |
| Other complications | ☐ | ☐ | ☐ |

| | Yes | No | Unknown |
|---|---|---|---|
| Does patient have unilateral/bilateral swelling of the parotid or other salivary gland lasting at least 2 days with no other apparent cause? | ☐ | ☐ | ☐ |

If yes, please list: _____

## LABORATORY TESTING

| | Yes | No | Unknown |
|---|---|---|---|
| Was lab test performed? | ☐ | ☐ | ☐ |
| Is this case epi-linked? | ☐ | ☐ | ☐ |

If yes, lit to whom: _____

Date of Lab Test _____

Name of Lab _____

Specimen Source _____

Type of test: ☐ Culture ☐ RT-PCR ☐ IgM ☐ IgG

Other? _____

Result: ☐ Positive ☐ Negative ☐ Equivocal

*NOTE:*
Serology samples should be collected 4-5 days post-onset.
Please test acute serology samples for IgM and IgG. If IgM is negative, collect an additional sample for IgG testing 2-5 weeks after onset for convalescent serology testing.
Culture samples should be collected no later than 9 days post-onset.

## VACCINATION HISTORY

| | Yes | No | Unknown |
|---|---|---|---|
| Was patient vaccinated with mumps vaccine? | ☐ | ☐ | ☐ |

| Date of Vaccination | Vaccine Type | Manufacturer | Lot Number | Physician or Institution where vaccine was given |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## ACTIVE SURVEILLANCE/CONTACTS

Please list any travel in the 18 days prior to onset:

### CONTACTS

| Name | Age | Address | Phone # | Date(s) of exposure | Vaccine history |
|---|---|---|---|---|---|
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Notes

## REPORTED BY

Name/Institution Phone Number Date