Mumps Case Report Form

Call (or fax) MCDH CD Program to report each suspect or confirmed case within 24 hours of receipt.

Phone: 815-334-4500 **Fax: 815-334-0191**

Reporter Information

Reporter Name:_____ Date of Report:_____
Physician: _____
Facility Name: _____
Location:_____
Phone Number:_____
Date/Time patient seen in clinic: _____

Incubation period: 12-25 days
Period of communicability: exclude from school/work for **5** days after onset of parotitis
Parotid Gland/Buccal swab preferred method of testing.
Vaccinated-collect within 1-3 days of parotitis onset.
Suspect pt should be masked while in office.

Patient Contact Information

Name:_____ DOB:_____ Sex:_____
Address:_____
Phone Number: _____
Parent/Guardian Name: _____

History of Immunization

History of Mumps Disease: ▫ Yes ▫ No Contact with anyone who was told they have mumps: ▫ Yes ▫ No
If yes, name of person:_____
Received mumps-containing vaccine: ▫ Yes (list dates below): ▫ No ▫ Unknown
Vaccine Name: _____ Date(s) received: _____ / _____
If no immunization, specify reason: _____

Clinical Information

▫ Parotitis: onset date: _____ duration: _____ ▫ Malaise ▫ Headache ▫ Loss of appetite
▫ Myalgia ▫ Fever (temperature: _____) ▫ other _____

Other

Occupation:_____ Name of Employer/School:_____
Date last worked: _____ City of Employment:_____

Recent history of travel? ▫ Yes ▫ No If yes, where: _____ When: _____
Any recent out-of-town visitors? ▫ Yes ▫ No From where:_____ When: _____

Has the patient been instructed to remain home until 5 days after the onset of parotitis ▫ Yes ▫ No
(The first day of parotitis is day 0)

What labs were collected ▫ Buccal Swab for mumps PCR ▫ Buccal Swab for mumps culture ▫ IgM ▫ IgG

Did the provider contact the local health department for authorization to send buccal swab to IDPH? ▫ Yes ▫ No

Was any other testing done:
Influenza ▫ Positive ▫ Negative ▫ Not Tested
Mononucleosis ▫ Positive ▫ Negative ▫ Not Tested
Strep Throat ▫ Positive ▫ Negative ▫ Not Tested
Other _____ ▫ Positive ▫ Negative