MDH Minnesota Department of Health

VACCINE PREVENTABLE DISEASE SECTION

Mumps Reporting Form

Patient Information

Patient's name: (last) (first) (MI)

Date of birth: ____/____/_____ Gender: ☐ Male ☐ Female ☐ Unknown

Phone: home ( ) - work ( ) -

Address:

City: State: ZIP:

County:

Race (check all that apply):
☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Black/African American ☐ Unknown ☐ Other:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Preferred language: ☐ English ☐ Other: Country of birth:

Occupation: Parent/guardian:

Laboratory and Facility Information

Medical record number:

Date of onset: ____/____/_____ Date reported to MDH: ____/____/_____

Reporter Name: Phone: ( ) -

Institution/clinic: City:

Ordering provider: Phone: ( ) -

Primary care provider: Phone: ( ) -

MDH contact if additional information needed (choose at least one):
☐ Reporter ☐ Ordering Provider ☐ Primary care provider ☐ Other: _____

Was patient hospitalized? ☐ Yes ☐ No ☐ Unknown Hospital name:

Mumps Specific Information

Did the patient have:

Parotitis ☐ Yes ☐ No ☐ Unknown Parotitis onset: ____/____/_____
Parotitis duration: _____ ☐ bilateral ☐ unilateral

Swelling of sublingual or submaxillary glands ☐ Yes ☐ No ☐ Unknown Swelling onset: ____/____/_____
Swelling duration: _____ ☐ bilateral ☐ unilateral

Orchitis ☐ Yes ☐ No ☐ Unknown Oophoritis: ☐ Yes ☐ No ☐ Unknown

Other symptoms: _____
(e.g., headache, anorexia, fatigue, fever, body aches, stiff neck, difficulty swallowing, nasal congestion, cough, etc.)

Other complications: _____
(e.g., deafness, encephalitis, mastitis, meningitis, pancreatitis, etc.)

Laboratory Information

Were specimens for RT-PCR collected and submitted to MDH (buccal swab or buccal swab and urine)?
☐ Yes—currently in progress ☐ No*

Was mumps IgM testing done at another lab facility? ☐ Yes ☐ No*
If yes, date specimen collected: ____/____ /_____
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Not done ☐ Unknown
Laboratory name: _____
**Mumps infection cannot be confirmed without laboratory testing.*

Vaccine History

Has the patient ever received any doses of mumps vaccine? ☐ Yes ☐ No ☐ Unknown
Please list the reason if the patient has not received **two doses** of mumps vaccine:
_____

Vaccination date: ____/____ /_____ ☐ Unknown	Vaccine Type: ☐ MMR II ☐ ProQuad (MMRV) ☐ Unknown ☐ Other	Lot number:
Vaccination date: ____/____ /_____ ☐ Unknown	Vaccine Type: ☐ MMR II ☐ ProQuad (MMRV) ☐ Unknown ☐ Other	Lot number:

Clinic name:

Source of vaccine information: ☐ Patient's or parent's verbal report ☐ Physician ☐ School records ☐ Unknown
☐ Other: _____

Epidemiologic Information

If known, where did the patient acquire mumps?:

Did the patient travel out-of-state one month before onset of symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, where: _____ Dates of travel: ____/____ /_____ to ____/____ /_____

Did the patient travel out of the county one month before onset of symptoms? ☐ Yes ☐ No ☐ Unknown
If yes, where: _____ Dates of travel: ____/____ /_____ to ____/____ /_____

Is the patient related to a mumps outbreak? ☐ Yes ☐ No ☐ Unknown
If yes, identify outbreak (e.g., school, child care name): _____

Diagnosis/Exclusion

What is the primary diagnosis for this patient? _____
(If mumps is the primary diagnosis, recommend exclusion through 5 days after onset of swelling/symptoms)

Are other differential diagnoses being considered? ☐ Yes ☐ No If yes, list: _____

If mumps RT-PCR result is negative, does the clinician feel comfortable ruling out mumps? ☐ Yes ☐ No
- **If yes**, health care provider should inform patient of results and lift exclusion recommendation.
- **If no**, patient should complete their 5 day exclusion period. Exclusion recommendations and test result should be communicated by the health care provider.
  (In previously vaccinated individuals, a negative RT-PCR result many not rule out mumps as they shed smaller amounts of virus for a shorter period of time and may cause a potentially falsely negative result)

Fax completed form to
1-800-295-9769

Vaccine Preventable Disease Section
PO Box 64975, St. Paul, MN 55164
651-201-5414
www.health.state.mn.us/immunize

To obtain this information in a different format, call: 651-201-5414