Massachusetts Department of Public Health

Received in DSAI:

Bureau of Communicable Disease Control

**Division of Surveillance, Analytics and Informatics**

305 South Street, Jamaica Plain MA 02130

*Phone****: 617-983-6801***  *Confidential Fax****: 617-887-8789 Fax to this number***

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| **TUBERCULOSIS***For assistance filling out this form, call (617) 983-6970* | **CONFIDENTIAL CASE REPORT** |
| ***(****leave this section blank for state health department use)* Report Status: 🞎 Confirmed 🞎 Suspect 🞎 Revoked |
| **DEMOGRAPHIC INFORMATION** |
| Last Name: First Name: Birth date:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |
| Address: Apt. #:  |
| City: State: Zip:  |
| Sex: 🞎 Female 🞎 Male 🞎 Transgender 🞎 Unk Contact Phone: (\_\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_ |
| Place of birth (e.g. specific country): Primary Language: |
| Occupation/ Employment: Work Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_ |
| Work Address:  |
| Race *(check all that apply):*  🞎 American Indian/ Alaskan Native 🞎 Asian 🞎 Black/ African American  🞎 Native Hawaiian/Pacific Islander 🞎 White 🞎 Other 🞎 Unk  |
| Hispanic: 🞎 Yes 🞎 No 🞎 Unk |
| Next of Kin: Phone:(\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| **CLINICAL INFORMATION** |
| Did case have any symptoms? 🞎 Yes 🞎 No 🞎 Unk Symptom onset date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Chest pain: 🞎 Yes 🞎 No 🞎 Unk Cough 🞎 Yes 🞎 No 🞎 UnkFever: 🞎 Yes 🞎 No 🞎 Unk Night sweats: 🞎 Yes 🞎 No 🞎 Unk Weight loss: 🞎 Yes 🞎 No 🞎 Unk Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| TST Test Result: 🞎 Positive 🞎 Negative 🞎 Previous Positive 🞎 Not Done 🞎 Unk Date Administered: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_mmQuantiFERON® Result:🞎 Positive 🞎 Negative 🞎 Indeterminate 🞎 Not Done  Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ % response\_\_\_\_\_\_\_\_ |
| Chest X-ray: 🞎 Done 🞎 Not Done 🞎 Unk Date Performed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Chest X-ray Result**:** 🞎 Normal 🞎 Abn Non-Cavitary 🞎 Abn Cavitary 🞎 Unk |
| Site(s) of Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Specimen Collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Collected: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  |
| Smear Result 🞎 Positive 🞎 Negative 🞎 Not Done 🞎 UnkCulture Result 🞎 Positive 🞎 Negative 🞎 Not Done 🞎 Unk |
| Medications Begun: 🞎 Yes 🞎 No 🞎 UnkDate Medications Started: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_Isoniazid (INH) Dose/Freq: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rifampin (RIF) Dose/Freq: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rifater (RFT) (fixed combination of INH, RIF, PZA) Tabs: \_\_\_\_\_\_\_\_ Freq: \_\_\_\_\_\_\_\_Rifamate (RFM) (fixed combination of INH and RIF) Tabs: \_\_\_\_\_\_\_\_ Freq: \_\_\_\_\_\_\_\_Pyrazinamide (PZA) Dose/Freq: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethambutol (EMB) Dose/Freq: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Case hospitalized? 🞎 Yes 🞎 No 🞎 Unk Date hospitalized: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Hospital name: Estimated discharge date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Patient record/ chart #:  |
| Outcome: 🞎 Died 🞎 Recovered 🞎 Unk Date of death: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| Discharge Planning Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Primary Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| TB Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Agency/Facility Reporting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person Completing Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| **Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

***617-887-8789 Fax to this number***