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 🞎 Unk  Fever: 🞎 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: \_\_\_\_\_\_\_\_\_mm  QuantiFERON® 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 🞎 Unk  Culture 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***