Massachusetts Department of Public Health
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***

Received in DSAI:

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

Please complete page 2.

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 ☐ Unk Date 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_____

_____

_____

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