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Massachusetts Department of Public Health
Bureau of Infectious Disease and Laboratory Sciences
Office of Integrated Surveillance and Informatics Services
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Received in Surveillance: ☐☐ / ☐☐ / ☐☐☐☐

COVID-19 Vaccine Breakthrough* Hospitalization or Death Report Form

Confidential Case Report

Symptom onset or earliest positive test must occur at least 14 days after the final dose of COVID-19 vaccine

Patient: Last **First** **Phone:** ( ) -

Address: **City:** **State:** **Zip:**

Date of Birth: (mm/dd/yyyy) / /

Hispanic: ☐ Yes ☐ No ☐ Unk **Sex:** ☐ Female ☐ Male ☐ Transgender ☐ Unk

Race:

- ☐ American Indian/Alaskan Native
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ Unk
- ☐ Asian
- ☐ Other
- ☐ White

Occupation: _____

Is case a healthcare worker? ☐ Yes ☐ No ☐ Unk

Check if resident of congregate living setting and note name of facility below:

- ☐ Correctional facility
- ☐ Long term Care Facility
- ☐ School/University/College
- ☐ Other (specify):

Name of Facility (if applicable):

_____

Clinical Information

Did patient have symptoms? ☐ Yes ☐ No ☐ Unk

Symptom Onset Date / /

Fever	☐ Yes	☐ No	☐ Unk
Chills	☐ Yes	☐ No	☐ Unk
Cough	☐ Yes	☐ No	☐ Unk
Shortness of Breath	☐ Yes	☐ No	☐ Unk
Headache	☐ Yes	☐ No	☐ Unk
Loss of Smell or Taste	☐ Yes	☐ No	☐ Unk
Myalgia	☐ Yes	☐ No	☐ Unk
Sore Throat	☐ Yes	☐ No	☐ Unk

Did patient develop pneumonia? ☐ Yes ☐ No ☐ Unk

Did patient develop acute respiratory distress syndrome (ARDS)? ☐ Yes ☐ No ☐ Unk

Is patient immunocompromised? ☐ Yes ☐ No ☐ Unk

Is patient pregnant? ☐ Yes ☐ No ☐ Unk

Does patient have any of the following?

- ☐ Cardiovascular Disease
- ☐ Chronic Pulmonary Disease
- ☐ Diabetes
- ☐ Chronic Renal Disease

Was patient hospitalized? ☐ Yes ☐ No ☐ Unk

Hospitalization Dates:

Admit: **Discharge:**

____ / ____ / ____ — ____ / ____ / ____

Hospital Name:

_____

Patient Outcome: ☐ Died ☐ Recovered ☐ Unknown

Date of Death: ____ / ____ / _____

Report COVID-19 infections resulting in hospitalization or death in fully vaccinated individuals ONLY. Fully vaccinated means at least 14 days after a final dose. Do not use for other COVID-19 case reporting.

Reporter's Name: (Last Name, First Name) **Date Completed: (mm/dd/yyyy)** / /

Facility: **Phone:** ( ) -

Make solid marks that fit in the response boxes. Please use black or blue ink. **Right way ->** A B **Wrong way ->** A B