Massachusetts Department of Public Health
Bureau of Communicable Disease Control
Office of Integrated Surveillance and Informatics Services
305 South Street, Jamaica Plain MA 02130

Phone: ***617-983-6801*** *Confidential Fax:* ***617-983-6813*** ⟵ ***Fax to this number***

Received in ISIS:

TUBERCULOSIS **CONFIDENTIAL CASE REPORT**

For assistance filling out this form, call (617) 983-6970

(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____

____

____

____

____

617-983-6813 ⬅ ***Fax to this number***