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***

Received in ISIS:

GENERIC CONFIDENTIAL CASE REPORT

Use this document only for those diseases without a specific reporting form
For assistance filling out this form, call (617) 983-6800

(leave this section blank for state health department use) Report Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Revoked

DEMOGRAPHIC INFORMATION

Last Name: First Name: MI:

Address: Apt. #:

City: State: Zip:

Unique Address Condition: ☐ Homeless ☐ Incarcerated

Contact phone: (____) _____-_____ Occupation:

Birth date: _____/_____/_____ Place of birth (e.g. specific country):

Age: _____ ☐ Years ☐ Months ☐ Weeks ☐ Days ☐ Unk

Sex: ☐ Female ☐ Male ☐ Transgender ☐ Unk

Race *(check all that apply):*
☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unk

Hispanic: ☐ Yes ☐ No ☐ Unk

CLINICAL INFORMATION

Disease:

Diagnosis date: _____/_____/_____

Did case have any symptoms? ☐ Yes ☐ No ☐ Unk Symptom onset date: _____/_____/_____

Diarrhea ☐ Yes ☐ No ☐ Unk Fever ☐ Yes (highest temp._____°F/°C) ☐ No ☐ Unk
Headache ☐ Yes ☐ No ☐ Unk Neurologic symptoms ☐ Yes ☐ No ☐ Unk
Rash ☐ Yes ☐ No ☐ Unk Vomiting ☐ Yes ☐ No ☐ Unk
Other (*specify*): _____

If case is ≤ 7 years of age and had meningitis, did the case have cochlear implants? ☐ Yes ☐ No ☐ Unk

Case hospitalized? ☐ Yes ☐ No ☐ Unk Date hospitalized: _____/_____/_____

Hospital name: Date discharged: _____/_____/_____

Outcome: ☐ Died ☐ Recovered ☐ Unk Date of death: _____/_____/_____

Clinician name and address:

Clinician phone: (_____) _____-_____ Patient record/ chart #:

DIAGNOSTIC LABORATORY TEST INFORMATION

Was laboratory testing done? ☐ Yes ☐ No ☐ Unk

Date specimen 1 collected: _____/_____/_____ Name of Laboratory:_____

Source: ☐ Stool ☐ Sputum ☐ Blood ☐ CSF ☐ Tissue ☐ Urine ☐ Other (*specify*): _____

Type of test: ☐ Culture ☐ Gram Stain ☐ Serology ☐ Microscopic analysis ☐ PCR ☐ Other (*specify*): _____

Please complete page 2. Include additional lab information if available.

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Other (*specify*): _____

Date specimen 2 collected: _____/_____/_____ Name of Laboratory:_____

Source: ☐ Stool ☐ Sputum ☐ Blood ☐ CSF ☐ Tissue ☐ Urine ☐ Other (*specify*): _____

Type of test: ☐ Culture ☐ Gram Stain ☐ Serology ☐ Microscopic analysis ☐ PCR ☐ Other (*specify*): _____

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Other (*specify*): _____

INFORMATION RELEVANT TO EXPOSURE, CONTROL AND PREVENTION

Did the case travel during the incubation period? ☐ Yes ☐ No ☐ Unk

If **yes**, when: _____/_____/_____to_____/_____/_____

Where to (*specify*)?: City: _____ State: _____ Country: _____

Enrolled or employed at a supervised care setting? ☐ Yes ☐ No☐ Unk

Select facility type: ☐ Daycare ☐ Long-term care facility

If yes, name and address of facility: _____

Attend or is employed at a school? ☐ Yes ☐ No ☐ Unk

If yes, name and address of school: _____

Place of employment: _____ Phone: (_____) _____-_____

Address: _____

Is case a foodhandler? ☐ Yes ☐ No ☐ Unk

Is case a health care worker? ☐ Yes ☐ No ☐ Unk

ADMINISTRATIVE INFORMATION

Comments:_____

_____

_____

_____

Investigator's name: _____ Phone: (____) _____ - _____

Agency: _____ Fax: (____) _____ - _____

Date first reported to you: ____/_____/_____ Date investigation started:____/____/____ Date form completed: ____/_____/____

(Leave this section blank for state health department use)

Case report reviewed by epidemiologist? ☐ Yes Name: _____ Date reviewed: ___/___/_____

Import Status: ☐ Unk ☐ Acquired in Massachusetts ☐ Acquired in USA outside MA what state? _____ ☐ Acquired outside USA what country? _____

Is case part of a current outbreak? ☐ Yes ☐ No ☐ Unk Outbreak name:_____