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:

TYPHOID FEVER

For assistance filling out this form, call (617) 983-6800

CONFIDENTIAL CASE REPORT

(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

Diagnosis date: _____/_____/_____

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

Abdominal pain ☐ Yes ☐ No ☐ Unk Constipation ☐ Yes ☐ No ☐ Unk
Cough ☐ Yes ☐ No ☐ Unk Diarrhea ☐ Yes ☐ No ☐ Unk
Fatigue ☐ Yes ☐ No ☐ Unk
Fever ☐ Yes (highest temp. _____°F/°C) ☐ No ☐ Unk Headache ☐ Yes ☐ No ☐ Unk
Hepatomegaly ☐ Yes ☐ No ☐ Unk Malaise ☐ Yes ☐ No ☐ Unk
Mental status change ☐ Yes ☐ No ☐ Unk Parotitis ☐ Yes ☐ No ☐ Unk
Rash ☐ Yes ☐ No ☐ Unk Splenomegaly ☐ Yes ☐ No ☐ Unk
Other (*specify):*_____

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

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

Type of test: ☐ Culture ☐ Other (*specify*): _____

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

☐ Culture positive If **yes**, date: _____/_____/_____

Source: ☐ Stool ☐ Blood ☐ Gall bladder ☐ Other *(specify):*_____

INFORMATION RELEVANT TO EXPOSURE, CONTROL AND PREVENTION

In the 30 days before symptom onset, did the case:

Travel out-of-state or out-of-country? ☐ Yes ☐ No ☐ Unk

If **yes**, specify when: _____/_____/_____ to _____/_____/_____

If **yes**, specify where: City: _____ State: _____ Country :_____

Principal reason for travel from/to U.S. for most recent trip

☐ Business ☐ Immigration to U.S. ☐ Tourism

☐ Visiting relatives or friends ☐ Other (*specify*)? _____

Live outside the United States? ☐ Yes ☐ No ☐ Unk

If **yes**: Country: 1._____ 2. _____ 3. _____

Date returned/arrived in U.S.: _____/_____/_____ _____/_____/_____ _____/_____/_____

Duration of stay in foreign country _____ _____ _____

Is case a foodhandler? ☐ Yes ☐ No ☐ Unk

If **yes**: Name/address of employment:_____

Was the case removed from work? ☐ Yes ☐ No ☐ Unk

Dates worked during infectious period:_____

If the foodhandler is back at work, when were the back-to-work criteria met (per 105 CMR 300.000)? _____/_____/_____

When was the board of health of the case's place of employment notified? _____/_____/_____

VACCINE AND IG INFORMATION

Did the patient receive typhoid vaccination (primary series or booster) within **five years** before onset of illness? ☐ Yes ☐ No ☐ Unk

If case was ever vaccinated against typhoid fever, specify:

	vaccine 1	vaccine 2	vaccine 3	vaccine 4	vaccine 5
Date:	____/____/____	____/____/____	____/____/____	____/____/____	____/____/_____
Type:	_____	_____	_____	_____	_____
Manuf:	_____	_____	_____	_____	_____
Lot #:	_____	_____	_____	_____	_____

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(two or more cases of typhoid fever associated by time and place) ?

☐ Yes ☐ No ☐ Unk Outbreak name:_____

Epi-linked to a CONFIRMED or PROBABLE case? ☐ Yes ☐ No ☐ Unk

If yes, was the carrier **previously known** to the health department? ☐ Yes ☐ No ☐ Unk