



Boston Public Health Commission  
 Communicable Disease Control Division  
 1010 Massachusetts Avenue  
 Boston, MA 02118  
 Phone: 617-534-5611 Fax: 617-534-5905

# Communicable Disease Reporting Form

**DIAGNOSIS:**

**ONSET DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

|                            |  |  |                |   |                    |  |                  |     |
|----------------------------|--|--|----------------|---|--------------------|--|------------------|-----|
| <b>Case Identification</b> | NAME, LAST   |  | FIRST          |   | DOB ____/____/____ |  |                  |     |
|                            | STREET ADDRESS   |  |                | APT. #  | CITY               |  | STATE            | ZIP |
|                            | PHONE ( )  |  | CELL PHONE ( ) |   | AGE                | GENDER <input type="checkbox"/> male <input type="checkbox"/> female |                  |     |
|                            | RACE <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other: _____ |  |                |   |                    |  |                  |     |
|                            | ETHNIC ORIGIN <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic  |  |                | NEEDS INTERPRETER? <input type="checkbox"/> yes <input type="checkbox"/> no Language: _____ |                    |  |                  |     |
|                            | CARETAKER/CONTACT INFO: (if other than case)   |  |                |   | PATIENT WORKPLACE: |  |                  |     |
|                            | WAS CASE HOSPITALIZED? <input type="checkbox"/> yes <input type="checkbox"/> no If yes: from ____/____/____ to ____/____/____  |  |                |   |                    |  | PATIENT RECORD # |     |

|  |  |   |                          |                          |                    |   |
|--|--|---|--------------------------|--------------------------|--------------------|---|
| <b>Laboratory Findings</b>                 | <b>Viral Hepatitis</b>   | <b>Please mail or fax a copy of lab results</b> | <b>Positive</b>          | <b>Negative</b>          | <b>Result Date</b> | <b>COMMENTS:</b><br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |
|  |  | Hepatitis A antibody (total)                    | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____     |   |
|  |  | Hepatitis A antibody (IgM)                      | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____     |   |
|  |  | Hepatitis B surface antigen*                    | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____     |   |
|  |  | Hepatitis B core antibody (IgM)                 | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____     |   |
|  |  | Hepatitis B surface antibody                    | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____     |   |
|  |  | Hepatitis C antibody                            | <input type="checkbox"/> | <input type="checkbox"/> | ____/____/____     |   |
|  | Hepatitis C PCR  | <input type="checkbox"/>                        | <input type="checkbox"/> | ____/____/____           |                    |   |
|  | *If female: Is case pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown<br>If yes, please give EDC: ____/____/____ |   |                          |                          |                    |   |
|  | <b>Meningitis</b>  | <b>Results</b>                                  |                          |                          |                    |   |
| CSF date: ____/____/____                   |  | Protein: _____                                  | Glucose: _____           | WBC: _____               | RBC: _____         |   |
| <b>Check all that apply:</b>               |  |   |                          |                          |                    |   |
| <input type="checkbox"/> CSF Smear         |  | Results: _____                                  |                          |                          |                    |   |
| <input type="checkbox"/> CSF Culture       |  | Results: _____                                  |                          |                          |                    |   |
| <input type="checkbox"/> CSF Other         | Type of Test: _____  | Results: _____                                  |                          |                          |                    |   |
| <input type="checkbox"/> Culture (non-CSF) | Specimen Type: _____   | Results: _____                                  |                          |                          |                    |   |
| <b>Other</b>                               | <b>Laboratory Test</b>   | <b>Specimen Type</b>                            | <b>Result</b>            | <b>Date</b>              |                    |   |
|  |  |   |                          | ____/____/____           |                    |   |
|  |  |   |                          | ____/____/____           |                    |   |

|                                  |   |                                  |                                     |                |                |                               |
|----------------------------------|---|----------------------------------|-------------------------------------|----------------|----------------|-------------------------------|
| <b>Reporting</b>                 | <b>Reporting Source</b> _____ Phone ( ) _____   |                                  |                                     |                |                |                               |
|                                  | Site _____ Address _____ Date ____/____/____  |                                  |                                     |                |                |                               |
|                                  | <table border="1"> <tr> <td><b>Primary HC Provider</b> _____</td> <td><b>Diagnosing HC Provider</b> _____</td> </tr> <tr> <td>Facility _____</td> <td>Facility _____</td> </tr> <tr> <td>Phone ( ) _____ Fax ( ) _____</td> <td>Phone ( ) _____ Fax ( ) _____</td> </tr> </table> | <b>Primary HC Provider</b> _____ | <b>Diagnosing HC Provider</b> _____ | Facility _____ | Facility _____ | Phone ( ) _____ Fax ( ) _____ |
| <b>Primary HC Provider</b> _____ | <b>Diagnosing HC Provider</b> _____   |                                  |                                     |                |                |                               |
| Facility _____                   | Facility _____  |                                  |                                     |                |                |                               |
| Phone ( ) _____ Fax ( ) _____    | Phone ( ) _____ Fax ( ) _____   |                                  |                                     |                |                |                               |



**BOSTON PUBLIC HEALTH COMMISSION**  
1010 Massachusetts Avenue, Boston, MA 02118  
Telephone: 617-534-5611 Confidential Fax: 617-534-5905

Healthcare Providers in Boston must report the following disease (suspect or confirmed) to the Boston Public Health Commission

Report **immediately** by phone (this includes both suspect and confirmed cases) to (617) 534-5611 and ask for the nurse on-call

|  |   |
|--|---|
| Any case of an unusual illness   | Meningitis, bacterial, community acquired                         |
| Any cluster/outbreak of illness (including but not limited to foodborne illness) | Meningococcal disease, invasive ( <i>Neisseria meningitidis</i> ) |
| Anthrax ( <i>Bacillus anthracis</i> )  | Monkeypox or other orthopox virus                                 |
| Botulism ( <i>Clostridium botulinum</i> )  | Plague ( <i>Yersinia pestis</i> )                                 |
| Brucellosis ( <i>Brucella sp.</i> )  | Polio   |
| Diphtheria ( <i>Corynebacterium diphtheriae</i> )                                | Rabies in humans  |
| Eastern equine encephalitis  | Rheumatic fever   |
| Group A streptococcus, invasive  | Rubella   |
| <i>Haemophilus influenzae</i> , invasive   | Severe acute respiratory syndrome (SARS)                          |
| Hantavirus   | Smallpox  |
| Hemolytic uremic syndrome  | Tetanus ( <i>Clostridium tetani</i> )                             |
| Hepatitis A (IgM+ only)  | Tularemia ( <i>Francisella tularensis</i> )                       |
| Influenza A virus, novel   | Typhoid fever ( <i>Salmonella typhi</i> )                         |
| Influenza, pediatric deaths (<18 years)  | Viral hemorrhagic fevers  |
| Measles  | West Nile virus   |

Report within **1 to 2 business days** (this includes both suspect and confirmed cases)

Telephone: (617) 534-5611 or Confidential Fax: (617) 534-5905 • Reporting forms are available on-line at [www.bphc.org](http://www.bphc.org)

|  |  |
|--|--|
| Amebiasis ( <i>Entamoeba histolytica</i> )   | Legionellosis ( <i>Legionella sp.</i> )  |
| Anaplasmosis ( <i>Anaplasma phagocytophilum</i> )  | Leptospirosis ( <i>Leptospira sp.</i> )  |
| Animal Bites   | Listeriosis ( <i>Listeria sp.</i> )  |
| Babesiosis ( <i>Babesia sp.</i> )  | Lyme disease ( <i>Borrelia burgdorferi</i> )   |
| Campylobacteriosis ( <i>Campylobacter sp.</i> )  | Lymphocytic choriomeningitis   |
| Chagas disease ( <i>Trypanosoma cruzi</i> )  | Malaria ( <i>Plasmodium falciparum</i> , <i>P. malariae</i> , <i>P. vivax</i> , <i>P. ovale</i> , <i>p. knowlesi</i> ) |
| Chickenpox (Varicella)   | Melioidosis ( <i>Burkholderia pseudomallei</i> )   |
| Cholera ( <i>Vibrio cholerae</i> )   | Meningitis, viral (aseptic), and other infectious (non-bacterial)  |
| Creutzfeldt-Jakob disease (CJD) and variant CJD  | Mumps  |
| Cryptococcosis ( <i>Cryptococcus neoformans</i> )  | Norovirus  |
| Cryptosporidiosis ( <i>Cryptosporidium sp.</i> )   | Pertussis ( <i>Bordetella pertussis</i> )  |
| Cyclosporiasis ( <i>Cyclospora cayetanensis</i> )  | Pneumococcal disease, invasive ( <i>Streptococcus pneumoniae</i> )   |
| Dengue   | Psittacosis ( <i>Chlamydophila psittaci</i> )  |
| Ehrlichiosis ( <i>Ehrlichia sp.</i> )  | Q fever ( <i>Coxiella burnetii</i> )   |
| Encephalitis, any cause  | Reye syndrome  |
| <i>Escherichia coli</i> O157:H7 (or other shiga-toxin producing <i>E. coli</i> )   | Rickettsialpox ( <i>Rickettsia akari</i> )   |
| Food poisoning and toxicity (includes poisoning by ciguatera, scombrototoxin, mushroom toxin, tetrodotoxin, paralytic shellfish and amnesic shellfish) | Rocky Mountain spotted fever ( <i>Rickettsia rickettsii</i> )  |
| Giardiasis ( <i>Giardia sp.</i> )  | Salmonellosis ( <i>Salmonella sp.</i> , non typhi)   |
| Glanders ( <i>Burkholderia mallei</i> )  | Shiga-toxin producing organisms  |
| Group B streptococcus, invasive  | Shigellosis ( <i>Shigella sp.</i> )  |
| Hansen's disease (leprosy)   | Toxic shock syndrome   |
| Hepatitis B (acute or chronic)   | Toxoplasmosis ( <i>Toxoplasma sp.</i> )  |
| Hepatitis C (acute or chronic)   | Trichinosis ( <i>Trichinella sp.</i> )   |
| Hepatitis – infectious, not otherwise specified  | Typhus ( <i>Rickettsia prowazekii</i> )  |
| Influenza (culture or rapid test positive)   | Vibriosis ( <i>Vibrio sp.</i> )  |
|  | Yellow fever   |
|  | Yersiniosis ( <i>Yersinia sp.</i> )  |

**CALL (617) 534-5611 FOR MORE INFORMATION OR TO REPORT A DISEASE**

During outbreaks, BPHC may request that other disease be reporting immediately. Local boards of health have the authority to collect pertinent information as part of epidemiological investigations (M.G.L. c.111, s.6)