

Missoula Public Health Infectious Disease Office 301 W. Alder Missoula, MT 59802-4123 Phone: 406-258-3896 missoula.co\idreporting After Business Hours phone: 911 www.MissoulaPublicHealth.org		County Health Department/Local Health Jurisdiction (LHJ) Use Only: LHJ Case ID _____ Control Measures Implemented ___/___/___ First report date to LHJ ___/___/___ LHJ Investigation start date ___/___/___ First report date to DPHHS ___/___/___ This report is: <input type="checkbox"/> Initial <input type="checkbox"/> Update: ___/___/___	DPHHS Use Only: MMWR Week _____ CDC Case Status <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable Disposition <input type="checkbox"/> CDC Notification <input type="checkbox"/> Out of State – faxed <input type="checkbox"/> Not a Case
<h1>Communicable Disease Case Report</h1>			
County/Tribal Jurisdiction			

This notification form fulfills the Administrative Rules of Montana (ARM) requirements for disease reporting. Supplemental disease specific forms may also be required. Disease specific forms are located at the DPHHS SharePoint site <http://contractor.hhs.mt.gov/CDEpi/CDEpifrm/Forms/AllItems.aspx>

1. CASE INFORMATION

		<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect		
Disease/Condition			Onset Date	Diagnosis Date
Hospitalized? <input type="checkbox"/> Y <input type="checkbox"/> N	Hospital Name		Admit Date	Discharge Date

2. CASE DEMOGRAPHIC INFORMATION

Last Name	First Name	MI	Birth date ___/___/___ Age ___	
Address			Current Sex <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Unknown	
City/Town	State	Zip	Race (check all that apply) <input type="checkbox"/> Amer Ind/AK Native <input type="checkbox"/> Asian <input type="checkbox"/> Native HI/other PI <input type="checkbox"/> Black/Afr Amer <input type="checkbox"/> White <input type="checkbox"/> Unknown	
County/Tribal Jurisdiction	Phone		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
Control Measures Implemented <input type="checkbox"/> Y <input type="checkbox"/> N Date implemented				

Sensitive Occupation: Food Handler Y N Patient Care Provider Y N Day Care Provider Y N
Attends Day Care Y N

3. LABORATORY INFORMATION

Ordering Facility	Laboratory Name		
Ordered Test	Collection Date	Reported Result	
Health Care Provider	Phone		

4. REPORTING INFORMATION

Reporter to LHJ	Phone
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5. NOTES

LHJ Investigator	Phone/email