|  |  |  |
| --- | --- | --- |
| <Please insert your jurisdiction’s contact information here> | ***County Health Department/Local Health Jurisdiction (LHJ) Use Only:*** | ***DPHHS 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: [ ] Initial [ ] Update:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | **MMWR Week** \_\_\_\_\_\_\_\_\_\_\_\_ |
| ***CDC Case Status***[ ]  Confirmed [ ]  Probable  |
| ***Disposition***[ ]  CDC Notification [ ]  Out of State – faxed[ ]  Not a Case |
| Communicable Disease Case Report |
| 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***](http://contractor.hhs.mt.gov/CDEpi/CDEpifrm/Forms/AllItems.aspx) |
| 1. CASE INFORMATION |
|  |  [ ]  Confirmed  [ ]  Probable  [ ]  Suspect  |  |  |
| **Disease/Condition** | **Onset Date** | **Diagnosis Date** |
| **Hospitalized? [ ]**  Y **[ ]**  N |  |  |  |
| **Hospital Name** | **Admit Date** | **Discharge Date** |
| **2. CASE DEMOGRAPHIC INFORMATION** |
|  |  |  | **Birth date** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Age** \_\_\_\_**Current Sex** [ ]  F [ ]  M [ ]  UnknownRace (check all that apply)[ ]  Amer Ind/AK Native [ ]  Asian[ ]  Native HI/other PI [ ]  Black/Afr Amer[ ]  White [ ]  Unknown**Ethnicity** [ ] Hispanic or Latino[ ] Not Hispanic or Latino |
| **Last Name** | **First Name** | **MI** |
|  |
| **Address** |
|  |  |  |
| **City/Town** | **State** | **Zip** |
|  |  |
| **County/Tribal Jurisdiction** | **Phone** |
| Control Measures Implemented [ ]  Y [ ]  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** |
| **5. NOTES** |
|  |
|  |  |
| **LHJ Investigator** | **Phone/email** |