



County Health Department/Local Health Jurisdiction (LHJ) Use Only:

DPHHS Use Only:

LHJ Case ID _____
 Reporter (check all that apply)
 Laboratory Hospital HCP DPHHS
 Public health agency Other

MMWR Week _____

CDC Case Status
 Confirmed Probable

First report date to LHJ ____/____/____

LHJ Investigation start date ____/____/____

First report date to DPHHS ____/____/____

Disposition
 CDC Notification
 Out of State – faxed
 Not a Case

This report is: Initial Update: ____/____/____

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 can be found on the Montana TCC: <http://mttcc.org>

1. CASE INFORMATION

Confirmed
 Probable
 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	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
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			

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
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