MONTANA
Department of Public Health & Human Services

Communicable Disease Case Report

County/Tribal Jurisdiction:

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

LHJ Case ID _____

Reporter (check all that apply)
☐ Laboratory ☐ Hospital ☐ HCP ☐ DPHHS
☐ Public health agency ☐ Other

First report date to LHJ ____/____/____

LHJ Investigation start date ____/____/____

First report date to DPHHS ____/____/____

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

DPHHS Use Only:

MMWR Week _____

CDC Case Status
☐ Confirmed ☐ Probable

Disposition
☐ CDC Notification
☐ Out of State – faxed
☐ Not a Case

1. REPORT SOURCE

Report Submitted by _____

Phone_____ **Date** _____

Health Care Provider _____

Phone_____

2. CASE DEMOGRAPHIC INFORMATION

Last Name	First Name	MI

Address

City/Town	State	Zip

County/Tribal Jurisdiction	Phone

Birth date ____/____/____ **Age** _____

Current Sex ☐ F ☐ M ☐ Unknown

Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Unknown

Sensitive Occupation Food Handler ☐ Y ☐ N Patient Care Provider ☐ Y ☐ N Day Care Provider ☐ Y ☐ N
Attends Day care? ☐ Y ☐ N

3. CASE INFORMATION

Disease/condition:

Onset date: ____/____/____

Classification: ☐ Confirmed ☐ Probable ☐ Suspect

Diagnosis date: ____/____/____

Laboratory Information (*Provide laboratory information below or attach supporting laboratory report)*

Ordering Facility	Laboratory Name	

Ordered Test	Collection Date	Lab Report Date

Reported Result

NOTES

Investigator:

Phone/email:

The initial notification form fulfills the Administrative Rules of Montana (ARM) requirements for disease reporting. A disease specific form may be required. Disease specific forms can be found on the Montana Training and Communication Center.
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