Fax completed form to 406.651.6430.
For questions about reporting please contact RiverStone Health Public Health at 406.247.3305.

Communicable Disease Case Report

County/Tribal Jurisdiction	

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: ☐**Initial** ☐**Update:** ____/____/____

DPHHS Use Only:

MMWR Week _____________

CDC Case Status
☐ Confirmed ☐ Probable

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

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

	☐ Confirmed ☐ Probable ☐ Suspect		
Disease/Condition		**Onset Date**	**Diagnosis Date**

Hospitalized? ☐ Y ☐ N

Hospital Name	**Admit Date**	**Discharge Date**

2. CASE DEMOGRAPHIC INFORMATION

Last Name	**First Name**	**MI**

Address

City/Town	**State**	**Zip**

County/Tribal Jurisdiction	**Phone**

Control Measures Implemented ☐ Y ☐ N Date implemented _____/_____/_____

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

Current Sex ☐ F ☐ M ☐ Unknown

Race (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

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