Public Health
Prevent. Promote. Protect.
Hill County Health Department

# 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

***This notification form fulfills the Administrative Rules of Montana (ARM) requirements for disease reporting. Supplemental disease specific forms may also be required.***

## 1. CASE INFORMATION

| Disease/Condition | ☐ Confirmed ☐ Probable ☐ Suspect | 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 |
|---|---|
| | |

**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. 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 |
|---|---|
| | |