

<b>Missoula City-County Health Department - Infectious Disease Office</b> 301 W. Alder Missoula, MT 59802-4123 Phone: 406-258-3896 FAX: 406-258-3610 After Business Hours phone: 911 www.missoulacounty.us/ID		<b>County Health Department/Local Health Jurisdiction (LHJ) Use Only:</b>  LHJ Case ID _____  Control Measures Implemented ___/___/___  First report date to LHJ ___/___/___  LHJ Investigation start date ___/___/___  First report date to DPHHS ___/___/___  This report is: <input type="checkbox"/> Initial <input type="checkbox"/> Update: ___/___/___	<b>DPHHS Use Only:</b>  MMWR Week _____  <b>CDC Case Status</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable  <b>Disposition</b> <input type="checkbox"/> CDC Notification <input type="checkbox"/> Out of State – faxed <input type="checkbox"/> Not a Case
<h1>Communicable Disease Case Report</h1>			
<b>County/Tribal Jurisdiction</b>			

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

		<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect		
<b>Disease/Condition</b>			<b>Onset Date</b>	<b>Diagnosis Date</b>
<b>Hospitalized?</b> <input type="checkbox"/> Y <input type="checkbox"/> N	<b>Hospital Name</b>		<b>Admit Date</b>	<b>Discharge Date</b>

### 2. CASE DEMOGRAPHIC INFORMATION

<b>Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Birth date</b> ___/___/___ <b>Age</b> ___
<b>Address</b>			<b>Current Sex</b> <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Unknown
<b>City/Town</b>	<b>State</b>	<b>Zip</b>	<b>Race (check all that apply)</b> <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
<b>County/Tribal Jurisdiction</b>	<b>Phone</b>		
<b>Control Measures Implemented</b> <input type="checkbox"/> Y <input type="checkbox"/> N <b>Date implemented</b> ___/___/___			
<b>Ethnicity</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> 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

<b>Ordering Facility</b>	<b>Laboratory Name</b>	
<b>Ordered Test</b>	<b>Collection Date</b>	<b>Reported Result</b>
<b>Health Care Provider</b>	<b>Phone</b>	

### 4. REPORTING INFORMATION

<b>Reporter to LHJ</b>	<b>Phone</b>
------------------------	--------------

### 5. NOTES

<b>LHJ Investigator</b>	<b>Phone/email</b>