Flathead City-County Health Department

Communicable Disease Program
1035 1st Ave West, Kalispell MT 59901
Phone: 406-751-8101
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Communicable Disease Case Report

County/Tribal Jurisdiction	Flathead County

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

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

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

LHJ Investigator	Phone/email