



Teton County Health Department  
 PHONE: 406-466-2562  
 FAX: 406-466-5292  
 AFTER HOURS PHONE: 406-466-5781

**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

# Communicable Disease Case Report

County/Tribal Jurisdiction \_\_\_\_\_

*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>	
<b>County/Tribal Jurisdiction</b>		<b>Phone</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>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>
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## 5. NOTES

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