

CONFIDENTIAL COMMUNICABLE DISEASE REPORTING FORM

REFERRING FACILITY INFORMATION

DATE: _____ INFECTION/DISEASE NAME: _____

REFERRING PERSON/FACILITY: _____ PHONE #: _____

ADDRESS: _____

PROVIDER NAME: _____ PHONE #: _____

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE #: _____ COUNTY OF RESIDENCE: _____

CURRENTLY INPATIENT?: Y N

GENDER: _____ RACE: _____ ETHNICITY: _____ FACILITY: _____

LABORATORY TESTS/TREATMENTS

DATE OF TEST: _____ RESULTS: _____

HAS PATIENT BEEN NOTIFIED OF RESULTS? Y N

TREATMENT PROVIDED? Y N MEDICATION NAME & DOSE: _____

DATE OF TREATMENT: _____

PLEASE FAX A COPY OF LAB REPORTS ALONG WITH THIS FORM TO THE COUNTY OF RESIDENCE.

CLINTON COUNTY
989-227-3126

GRATIOT COUNTY
989-875-1032

MONTCALM COUNTY
989-831-3666