

**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**