



COMMUNICABLE DISEASE CASE REPORT

Disease / Infection				Date of Onset		Date of Report	
Patient's Name				Birth Date		Sex M F U	
Address	Street, Apt, Box #			Race Af As C O Unk		Ethnicity H N-H O	
	City	County	Zip	Phones	Home -		
School / Work					Work -		
Contact (Spouse, Parent, Guardian)				Cell -			
Contact (Spouse, Parent, Guardian)				Client aware of diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Reporting Entity		Notes					
Phone							
Test Date, Test Results, Treatment							
Phone Report to: 269-969-6383				Fax Report to: 269-969-6488			
CCPHD Communicable Disease Surveillance, 190 E Michigan Ave, Battle Creek, MI 49014							