

COMMUNICABLE DISEASE CASE REPORT

Disease / Infection				Date of Report		Date of Onset	
Patient's Name					Sex	Birth Date	
Address	Street, Apt, Box #				Phones	Home -	
	City		County	Zip		Work -	
School / Work & Title				Race		Ethnicity	
Contact (Spouse, Parent, Guardian)					Contact Phone		
Last Test Results			Test Date		Client Aware of Dx?		
Treatment / Other Remarks					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
					If Hepatitis B or C: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic		
Name of Reporting Physician			Practice / Facility		Phone		
Hospital / Lab				Admission Date		Discharge Date	
Fax Report to: 269-373-5060				Phone Report to: 269-373-5044			
				Mail Report to: Kalamazoo County HCS, Attn: Disease Surveillance 311 E. Alcott Street, Kalamazoo, MI 49001			