MONTGOMERY COUNTY HEALTH DEPARTMENT
DIVISION OF COMMUNICABLE DISEASE CONTROL

CONFIDENTIAL REPORTABLE DISEASE FORM
Revised September 2010

COUNTY OF RESIDENCE (CHECK ONE)
MONTGOMERY _____
OTHER: _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Gender:** M / F / UNK

Guardian (If Under 18)**:** _____ **Date of Birth:** _____/_____/_____ Age**:** _____Year/Month/Day

Address: _____ **City:** _____

Twp/Boro: _____ **State:** _____ **ZIP:** _____ **Telephone:** (_____) _____

OCCUPATION (Indicate One)

_____Food Service/Restaurant
_____Student/School
_____Health Care Professional
_____Inmate
_____Other_____
_____Day Care Attendee
_____Nursing/Group Home Resident
_____Unknown

RACE and **ETHNICITY** (Indicate One)

_____White
_____African-American/Black
_____Asian
_____American Indian/Alaska Native
_____Native Hawaiian/Pacific Islander
_____Other_____
_____Unknown
_____Hispanic/Latino
_____Non-Hispanic/ Non-Latino
_____Unknown

ATTENDING PHYSICIAN: _____ PHYSICIAN PHONE :(_____) _____

Name of Practice: _____ Address: _____

City: _____ State: _____ Zip: _____

HOSPITALIZED? ___Yes ___No ___ER Only Name of Hospital: _____

Date of Admission: ____/____/_____ Date of Discharge: ____/____/_____ Chart / Medical Record: _____

DISEASE or UNUSUAL OCCURENCE REPORTED: (_____)

Date of First Symptom: _____/_____/_____ **Date of Diagnosis:** ____/____/_____ **Treat/Rx:** _____

Laboratory Findings: _____ **Date Collected:** ____/____/_____

Specimen Source: (Circle One) Blood / CSF / Feces / Sputum / Urine / Synovial Fluid / Wound / Other-_____

Signs / Symptoms: (Circle One) Fever_____°F/ Nausea / Vomit / Diarrhea / Headache / Other-_____

Patient Travel? Y / N **Location:** _____ **Dates:** _____**Others ill?** Y / N

Food/ Drink Consumed: _____ **Date/Time ate:** ____/_____/_____

Name & Location of Eatery: _____

ADDITIONAL INFORMATION (If **Animal Bite**, list owner name, address and telephone number of biting animal)

_____

_____

REPORTING SOURCE

Name: _____Telephone: (_____) _____ DATE OF REPORT: ___/___/_____

Facility: _____ Address: _____

_____

REPORTING INFORMATION

Reports may be telephoned, faxed or mailed to:

Phone: (610) 278-5117 FAX: (610) 278-3971

Regular Business Hours: 8:00 AM – 4:30 PM

Emergencies or After Hours: (610) 275-1222

Division of Communicable Disease Control
Montgomery County Health Department
P.O. Box 311
1430 DeKalb St.
Norristown, PA 19404-0311