Communicable Disease Notifying Form

Health Protection Agency
Male', Republic of Maldives

V8 - Oct - 2019

Reporting Facility	☐***Re-notification** (required for changes in diagnosis (e.g. Dengue Fever to DHF), case confirmation or outcome (e.g. death).

Notifiable Diseases (place ✓appropriately)

Immediately notifiable via form and Telephone (✆+960 3014496/contact HPA surveillance focal point)	**Notifiable within 24 hrs. to HPA via email (surveillancereportshpa@gmail.com) or fax (+9603014484)**
☐ AEFI ☐ Acute Flaccid Paralysis (use Polio investigation form) ☐ Cholera ☐ Diphtheria ☐ Encephalitis (specify organism if known) ☐ Food Poisoning (use investigation form) ☐ Measles (complete measles investigation form) ☐ Meningitis (specify organism if known) ☐ Mumps ☐ MERS (Middle East Respiratory Syndrome) ☐ Pertussis/whooping cough (use investigation form) ☐ Rabies ☐ Rubella/Congenital Rubella Syndrome (use investigation form) ☐ Shigella ☐ Tetanus / £ Neonatal tetanus ☐ Tuberculosis (use TB investigation form) ☐ Yellow Fever	☐ Chikungunya £ Zika (complete investigation form) ☐ DF/£DHF/£DSS ☐ GBS (Guillain–Barré syndrome) ☐ Hepatitis A / B/ C/ D/E (circle as appropriate) ☐ Lymphatic Filariasis ☐ Leprosy ☐ Leptospirosis ☐ Malaria ☐ Plague ☐ Pyrexia of unknown origin (PUO) Pneumonia with cause ☐ Rota virus (complete Rota virus lab surveillance form) ☐ Scrub Typhus ☐ SARI (Severe Acute Respiratory Infection = ARI requiring hospital admission) ☐ Scabies ☐ STIs – Gonorrhea/Chlamydia/Genital warts/Genital Herpes (Circle as appropriate) ☐ Syphilis / ☐ Congenital Syphilis ☐ Typhoid/ ☐ Paratyphoid (complete case investigation form) ☐ Toxoplasmosis/ ☐ Congenital toxoplasmosis ☐ Others (specify) _____

Case Details (Mandatory fields are marked with (*) and underlined. Please make sure to complete them.

1-*Case classification: Suspect ☐ Probable ☐ Confirmed ☐ (as per surveillance case definition)

2-*Patient National ID No: A_____ For foreigners include passport number	3-***Patient Name:**	**4-*Age:** YY / MM	**5-*Sex:** ☐M ☐F If pregnant ☐

6- *Patient's residential Address with Atoll/Island (Usual address of residence)	**7-* Patient's permanent Address with Atoll/Island**	**8-Contact number✆**	**9-Nationality** country of origin

10-*Date of onset of illness: DD / MM / YYYY

11-Date of consultation: DD/ MM /YYYY

12-*Patient category

☐**Out-patient**

☐**In-patient:** ☐ Ward _____ Bed _____
☐ICU _____ Bed _____

13-*Case outcome:

☐ Death ☐ On treatment ☐ Referred to higher center

☐ Recovered with disability ☐ Recovered fully

***If on treatment, specify what is being given**

14- Recent travel history (include countries/islands visited)

15- Dates of travel DD/ MM/ YYYY

16-Clinical details (include risk factors, mode of transmission, etc.)

17-Laboratory Confirmation:

☐ Confirmed: Test specifics_____

☐ If Requested, Date: DD/ MM /YYYY

☐ Not Requested

18- Condition of patient: ☐ Stable ☐ Sick ☐ Critically ill

Notifier details (e.g.: Dr, Nurse, HW or another designated person)

Name: _____Designation: _____

Contact number: _____

Signature: _____ Date: DD/ MM/ YYYY

Data entry use (use by PHUs and entry users)

Date received: DD/ MM/ YYYY Date of entry: DD/ MM/ YYYY

Checked and entered by: _____