Communicable Disease Notifying Form

Health Protection Agency
Lot No. 11506, Onu Gas Magu,
Hulhumale', Republic of Maldives

HPA-SUR-U00049-F-2024-11

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 (✆+9603024525/contact HPA surveillance focal point)	**Notifiable within 24 hrs. to HPA via email (phpse.hpa@health.gov.mv)**
☐Adverse Event Following Immunization (use AEFI form) ☐Acute Flaccid Paralysis (use Polio investigation form) ☐Cholera ☐Diphtheria ☐Encephalitis (specify organism if known) ☐Food Poisoning (use investigation form) ☐Leprosy ☐Lymphatic Filariasis ☐Malaria ☐Measles (complete fever and rash investigation form) ☐Meningitis (specify organism if known) ☐Mpox ☐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 ☐Yellow Fever	☐Chikungunya / ☐Zika ☐COVID-19 ☐Dengue Fever (DF) / ☐Severe Dengue Fever ☐GBS (Guillain–Barré syndrome) ☐Hepatitis A / B/ C/ D/E (circle as appropriate) ☐Influenza (☐SARI / ☐ILI) ☐Leptospirosis ☐Plague ☐Pneumonia with cause ☐Rota virus ☐Scrub Typhus ☐Scabies ☐STIs (specify) _____ ☐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: 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:** ☐ Type of sample: *name the type of sample taken* ☐ Sample collection Date: *DD/ MM /YYYY HH/MM* ☐ Confirmed: *Specify the test* ☐ If Requested, Date: *DD/ MM /YYYY* ☐ Not Requested: *Reason*
18-Condition of patient: ☐Stable ☐Sick ☐Critically ill	**20-Data entry use (use by PHUs and entry users)**
19-Notifier details (e.g.: Dr, Nurse, HW or another designated person) Name:_____ Designation: _____ Contact number: _____ Date: *DD/ MM/ YYYY* Signature:	1- Data Entry Date: ___ /____ /_____ 2- Name: _____ 3- Signature: