

Instructions for completing notification forms

The adoption by the 58th World Health Assembly of the revised (2005) International Health Regulations (IHR) provides the legal framework for mandating countries to have a disease surveillance system. Therefore it is **Mandatory** under the International *Health Regulations (IHR)* to **report** communicable diseases.

(*) Questions marked with this asterisk are **mandatory** to complete.

1. Reporting institution name and contact phone number should be in each form. (a seal may be used)
2. Tick the appropriate notifiable disease. The diseases in **bold** in this list should be notified within **24 hours**. For a new emerging disease, i.e. a disease new to Maldives or not frequently seen, specify the disease in the space, and inform by telephone as well. For other diseases not listed, please see notes below.
3. **Case classification**: if uncertain, please check case definitions and confirmatory lab tests with the booklet: *Case definition for notifiable diseases in Maldives 2008*, available in hospitals and on the Ministry of Health and Family website.
4. Name: as in ID card, passport or work permit card (for non-nationals)
5. Permanent address: as in ID card (and usually in admission/registration documents)
6. **Address of residence** at time of onset of illness: Please specifically ask the patient or care-giver and write the address **where patient lived when the symptoms began**.
7. **Date of onset** = approximate date **when symptoms first began**. Please ask the patient or caregiver if it is not mentioned or not clear in the notes.
8. **Re-notification**: This is required for changes in diagnosis, case confirmation or outcome.
 - Change of diagnosis includes change from DF (Dengue fever) to DHF or DSS.
 - Case confirmation includes change in status i.e. suspect, probable or confirmed according to the case definition, e.g. confirming diagnosis or causative organism by laboratory tests.
 - Case outcome: This is often not known at time of reporting. However, if a patient with the disease dies, develops life-long sequelae or disability, or develops chronic disease status or chronic carrier status, please repeat notification mentioning the new outcome. In case of death, please attach a copy of death certificate and death summary.

You may use either the previous form, a clear copy of it or a fresh form for re-notification.

The following diseases do not require case-based notification:

- Viral fever
- Diarrhoeal disease (AGE)
- Out-patient Acute Respiratory Infections (ARIs)
- Conjunctivitis

This form need not be completed for these diseases unless you have some particular concern. These diseases are notified by institutions on a daily count basis.

The following diseases have separate forms which are available from CCHDC and on the website

- Acute flaccid paralysis (AFP)
- Tuberculosis
- Measles
- Vaccine preventable diseases
- HIV, STD's
- Food poisoning

These diseases should be informed to CCHDC by **telephone** as soon as possible. You may report it in this form under 'Other emerging diseases' and specify the name, if you wish, particularly when specific forms are not available. However, you should complete and send the disease-specific form also.

For further information or inquiries, please contact:

Health Protection Agency

Roshanee Building, Sosun Magu, Male'.

Telephone: +960 3014 496, Hotline: +960 3014 333

Fax: +960 3014 484

Forms and case definition booklet are available on <http://www.health.gov.mv>



Communicable Disease Notifying Form

CCHDC-V5-Feb-2012

Health Protection Agency

Male', Republic of Maldives

***Reporting Institution**, address and contact numbers (for tracing further information if required):

*** Case based Notifiable Diseases** (place ✓ appropriately)

- | | | | |
|---|---|-------------------------------------|--|
| <input type="checkbox"/> Acute Flaccid Paralysis | <input type="checkbox"/> Encephalitis _____ | <input type="checkbox"/> Measles | <input type="checkbox"/> Scrub Typhus |
| <input type="checkbox"/> Chickenpox / <input type="checkbox"/> Zoster | <input type="checkbox"/> Filariasis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tetanus/ <input type="checkbox"/> Neonatal |
| <input type="checkbox"/> Chikungunya | <input type="checkbox"/> Hand, Foot & Mouth Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid/ <input type="checkbox"/> Paratyphoid |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Hepatitis: Type A/B/C/D/E | <input type="checkbox"/> Plague | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Dengue fever/ <input type="checkbox"/> DHF/ <input type="checkbox"/> DSS | <input type="checkbox"/> Leprosy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Yellow Fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Leptospirosis | <input type="checkbox"/> Rubella | <input type="checkbox"/> Other emerging disease _____ |
| <input type="checkbox"/> Dysentery | <input type="checkbox"/> Malaria | | |

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

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

| | | | |
|-----------------------------|-------------------------------------|--|----------------------------------|
| *Patient Name: _____ | *Age: ____/____ (YY / MM) | *Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Registration number _____ |
|-----------------------------|-------------------------------------|--|----------------------------------|

| | | | |
|--|--------------|---------------|---|
| Permanent Address: _____ (For identification) | Atoll: _____ | Island: _____ | <input type="checkbox"/> If Non-national: Country of origin _____ |
|--|--------------|---------------|---|

| | | | |
|--|----------------------|-----------------------|---------------------------------|
| *Residential Address: _____ (At the time of contracting illness) | *Atoll: _____ | *Island: _____ | Contact Phone no.: _____ |
|--|----------------------|-----------------------|---------------------------------|

| | |
|--|---|
| *Date of onset of illness: ____/____/____ DD / MM / YYYY | *Date of Consultation /Admission: ____/____/____ DD / MM / YYYY |
|--|---|

| | |
|--|---|
| *Patient category <input type="checkbox"/> Out-patient <input type="checkbox"/> In-patient: <input type="checkbox"/> Ward _____ Bed _____ <input type="checkbox"/> ICU _____ Bed _____ | Clinical details (include risk factors, mode of transmission, etc.) |
|--|---|

| | |
|---|---|
| Recent travel history if relevant (include countries visited) | Date of arrival in Maldives: ____/____/____ DD / MM / YYYY |
|---|---|

| | |
|---|--|
| Condition of patient: <input type="checkbox"/> Stable <input type="checkbox"/> Sick <input type="checkbox"/> Critically ill | Laboratory Confirmation: <input type="checkbox"/> Confirmed: Test specifics _____ <input type="checkbox"/> If Requested, Date: ____/____/____ DD / MM / YYYY <input type="checkbox"/> Not Requested |
|---|--|

***Case outcome:**
 Death On treatment Referred to higher centre
 Recovered with disability Recovered fully

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

Notifier details
Name: _____ Designation: _____
Signature: _____ Date: ____/____/____

Data entry use
Date received: ____/____/____; Date of entry: ____/____/____
Checked and entered by: _____

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