health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Enhanced COVID-19 Notifiable Medical Conditions (NMC) Notification Form

{Section 90 (1) (j), (k) and (w) of National Health Act, 2003 (Act no. 61 of 2003)}

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

This form must be **completed immediately** by the health care provider who diagnosed the condition ***Please mark applicable areas with an X***

Health facility name *(with provincial prefix)*		Health facility contact number		Health district	
Patient file/folder number	Patient HPRS-PRN		Date of notification	y y y y - m m - d d	
Patient demographics			Patient residential address		
First name			*Street/dwelling unit/building/ERF number*		
Surname			*Street name, building, location description*		
RSA ID/Passport number			*Sub-place, suburb, village, postal area*		
Citizenship			*Town/city*	*Post code:*	
Ethnic group	*Black African*	*Coloured* / *Indian/Asian* / *White* / *Other*	**Employer/educational institution address**		
Date of birth	y y y y - m m - d d		*Institution name*		
Age	*Years*	*Months (If less than 1 year)* / *Days (if less than 1 month)*	*Street name, building, location description*		
Gender	*Male* / *Female*	*Self-defined*	*Sub-place, suburb, village, postal area*		
Contact number		*Alternative contact number*	*Town/city*	*Post code:*	
Next of kin			Contact number		
Name			**Occupation**		
Surname			Unemployed / Student / Healthcare worker		
Relationship to the patient			Health laboratory worker / Other	(specify)	
Contact number			**Hospitalisation**		
Medical condition details			Admission status	*Outpatient* / *Inpatient*	
Medical condition	*This form is for notifying COVID-19 case only*		Clinically required hospitalisation	*Yes* / *No*	
Was the patient previously tested for COVID-19?			Date of admission	y y y y - m m - d d	
	Yes (if repeat test) / No (if first test) / Unknown		Level of care	General ward / High Care / ICU	
Date of symptom onset	y y y y - m m - d d		If High Care/ICU		
Symptoms	Fever (≥38°C) / Sore throat / Cough / Shortness of breath		Date entered High Care /ICU	y y y y - m m - d d	
	Myalgia/body aches / Diarrhea / Other		Date exited High Care/ ICU	y y y y - m m - d d	
Case severity	Asymptomatic / Mild[1] / Moderate[2] / Severe[3]		**Oxygen requirements during hospitalisation**		
Date of diagnosis	y y y y - m m - d d		Room air / Nasal cannula oxygen		
Method of diagnosis	Clinical signs and symptoms ONLY / Laboratory confirmed		Mechanical ventilation		
	Rapid test / X-Ray / Other		Start date	y y y y - m m - d d	End y y y y - m m - d d
Source of PUI[4]	Field testing / Health facility / Healthcare professional		ECMO		
Name of source of PUI			Start date	y y y y - m m - d d	End y y y y - m m - d d
Patient received systemic antimicrobial treatment during hospital admission for a probable or confirmed healthcare-associated infection				Yes / No / Unknown	

[1]Mild - not requiring hospitalization for clinical reasons
[2]Moderate - requiring hospitalization
[3]Severe - requiring high care/ICU
[4] PUI - Person under investigation

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Underlying factors/comorbid conditions

HIV	Yes		No		Unknown	
TB	Yes		No		Unknown	
COPD	Yes		No		Unknown	
Hypertension	Yes		No		Unknown	
Diabetes	Yes		No		Unknown	
Asthma	Yes		No		Unknown	
Obesity	Yes		No		Unknown	
Pregnancy	Yes		No		Unknown	
Cancer	Yes		No		Unknown	
If TB, is patient on TB treatment	Yes		No		Unknown	
If yes, TB treatment start date	y y y y	-	m m	-	d d	
If living with HIV, is patient on ART?	Yes		No		Unknown	
If yes, is there viral suppression?	Yes		No		Unknown	

History of close physical contact with confirmed COVID-19 case in past 14 days

Close physical contact with a known COVID-19 case	Yes		No		Unknown	
If yes, please indicate the contact setting						
Quarantine Centre		Healthcare setting		Family setting	Workplace	
Other, specify						

Hospital outcome

Status	Discharged		In hospital		Transferred		Died	
If discharged, date	y y y y	-	m m	-	d d			
If died, date	y y y y	-	m m	-	d d			

Outcome of patient cared for at home after 14 days of symptom onset/test date

Alive, asymptomatic		Alive, symptomatic		Died	

Specimen details

Was the specimen collected	Yes		No	
Date of collection	y y y y	-	m m	- d d
Specimen barcode/lab number				

Travel history in the last 14 days

Did patient travel outside of usual place of residence?	Yes		No	

Place travelled from	Place travelled to	Date left usual place of residence	Date returned to usual place of residence

Notifying health care provider's details

First name		Mobile number	
Surname		Email address	
Notifier's signature		SANC/HPCSA number	

Send to NMCsurveillanceReport@nicd.ac.za or fax to 086 639 1638 or NMC hotline 072 621 3805 and to the sub-district/district office