

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)}

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																								

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

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Underlying factors/comorbid conditions										Hospital outcome																		
HIV	Yes		No		Unknown					Status	Discharged			In hospital			Transferred			Died								
TB	Yes		No		Unknown					If discharged, date	y	y	y	y	-	m	m	-	d	d								
COPD	Yes		No		Unknown					If died, date	y	y	y	y	-	m	m	-	d	d								
Hypertension										Outcome of patient cared for at home after 14 days of symptom onset/test date																		
Diabetes	Yes		No		Unknown					Alive, asymptomatic	Alive, symptomatic			Died														
Asthma										Specimen details																		
Obesity	Yes		No		Unknown					Was the specimen collected	Yes			No														
Pregnancy	Yes		No		Unknown					Date of collection	y	y	y	y	-	m	m	-	d	d								
Cancer	Yes		No		Unknown					Specimen barcode/lab number																		
If TB, is patient on TB treatment										Travel history in the last 14 days																		
If yes, TB treatment start date										y	y	y	y	-	m	m	-	d	d	Did patient travel outside of usual place of residence?					Yes	No		
If living with HIV, is patient on ART?										Yes		No		Unknown					Place travelled from	Place travelled to			Date left usual place of residence			Date returned to usual place of residence		
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																												
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](tel:0866391638) or NMC hotline [072 621 3805](tel:0726213805) and to the sub-district/district office