

Notifiable Medical Conditions (NMC) Case 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 <i>(with provincial prefix)</i>										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															<i>Street/dwelling unit/building/ERF number</i>																																											
Surname															<i>Street name, building, location description</i>																																											
S.A ID number															<i>Sub-place, suburb, village, postal area</i>																																											
Passport/other ID number															<i>Town/city</i>															<i>Post code:</i>																												
Citizenship															Employer/educational institution address																																											
Date of birth															<i>Institution name</i>																																											
Age					<i>Years</i>					<i>Months (if less than 1yr)</i>					<i>Days (if less than 1 month)</i>					<i>Street name, building, location description</i>																																						
Gender					<i>Male</i>					<i>Female</i>					<i>Sub-place, suburb, village, postal area</i>																																											
Is patient pregnant?					<i>Yes</i>					<i>No</i>					<i>Unknown</i>					<i>Town/city</i>															<i>Post code:</i>																							
Contact number															Contact number																																											
Medical conditions details																																																										
Name of NMC diagnosed															History of possible exposure to NMC in the last 60dys										<i>No</i>					<i>Yes</i>					<i>Unknown</i>																							
Method of diagnosis															<i>Clinical signs and symptoms ONLY</i>					<i>Rapid test</i>					<i>X-ray</i>					<i>Laboratory confirmed</i>					<i>Other:</i>																							
Clinical symptoms relating to the NMC																																																										
Treatment given for the NMC																																																										
Date of diagnosis															y					y	y	y	-	m	m	-	d	d	Date of symptom onset										y					y	y	y	-	m	m	-	d	d						
Patient admission status															<i>Outpatient</i>					<i>Discharged</i>					<i>Inpatient</i>					Ward name																												
Patient vital status															<i>Alive</i>					<i>Deceased</i>					Date of death										y					y	y	y	-	m	m	-	d	d										
Travel history in the last 60 days																																																										
Did patient travel outside of usual place of residence?															<i>Yes</i>					<i>No</i>					<i>If yes, complete the travel details below</i>																																	
Place travelled from										Place travelled to										Date patient left usual place of residence										Date patient returned to usual place of residence																												
<i>Country/Province/Town</i>										<i>Country/Province/Town</i>										y					y	y	y	-	m	m	-	d	d	y					y	y	y	-	m	m	-	d	d											
<i>Country/Province/Town</i>										<i>Country/Province/Town</i>										y					y	y	y	-	m	m	-	d	d	y					y	y	y	-	m	m	-	d	d											
Vaccination history for the NMC diagnosed above (complete only for vaccine preventable NMC)																																																										
Vaccination status															<i>Not vaccinated</i>					<i>Up-to-date</i>					<i>Unknown</i>					Date of last vaccination															y					y	y	y	-	m	m	-	d	d
Specimen details															Notifying health care provider's details																																											
Was a specimen collected?															<i>Yes</i>					<i>No</i>					First name																																	
Date of specimen															y					y	y	y	-	m	m	-	d	d	Surname																													
Specimen barcode/lab number															Mobile number																																											
															SANC/HPCSA number															Notifier's signature																												

The top copy (white) must be sent to NMCsurveillanceReport@nicd.ac.za or fax to 086 639 1638 or NMC hotline 072 621 3805 and to the sub-district/district office. The middle copy (blue) must be attached to the patient referral letter or patient file. The bottom copy (pink) must remain in the booklet