ANNEX 7

NOTIFICATION FORM

JADUAL
(Peraturan 2)
Borang
(Peraturan 2)
AKTA PENCEGAHAN DAN PENGAWALAN PENYAKIT BERJANGKIT 1988
PERATURAN-PERATURAN PENCEGAHAN DAN PENGAWALAN PENYAKIT BERJANGKIT (BORANG NOTIS (PINDAAN) 2011

Borang Notis: Rev/2010
No. Siri:

NOTIFIKASI PENYAKIT BERJANGKIT YANG PERLU DILAPORKAN

(Seksyen 10, Akta Pencegahan Dan Pengawalan Penyakit Berjangkit 1988)

A. MAKLUMAT PESAKIT

1. Nama Penuh (HURUF BESAR):

Nama Pengiring (Ibu/Bapa/Penjaga):
(Jika belum mempunyai Kad Pengenalan diri)

2. No. Kad Pengenalan Diri / Dokumen Perjalanan ☐ Sendiri ☐ Pengiring
(Untuk Bukan Warganegara)

No. Daftar Hospital / Klinik Nama Wad:_____ Tarikh Masuk Wad: / /

3. Kewarganegaraan:
Warganegara:
☐ Ya Keturunan:
Sukuketurunan:
(Bagi O/Asli, Pribumi Sabah/Sarawak)
☐ Tidak Negara Asal:
Status Kedatangan: ☐ Izin ☐ Tanpa Izin ☐ Penduduk Tetap

4. Jantina: ☐ Lelaki ☐ Perempuan

5. Tarikh Lahir: / /

6. Umur: ☐ Tahun ☐ Bulan ☐ Hari

7. Pekerjaan:_____
(Jika tidak bekerja, nyatakan status diri)

8. No. Telefon: ☐ Rumah ☐ Tel. Bimbit ☐ Pejabat -
(Untuk dihubungi)

9. Alamat Kediaman

10. Alamat Tempat Kerja / Belajar:

B. DIAGNOSIS PENYAKIT

☐ 1. Poliomyelitis	☐ 16. Hand, Food and Mouth Disease	☐ 31. Tetanus Neonatorum
☐ 2. Viral Hepatitis A	☐ 17. Human Immunodeficiency Virus Infection	☐ 32. Tetanus (Others)
☐ 3. Viral Hepatitis B	☐ 18. Leprosy (Multibacillary)	☐ 33. Typhus - Scrub
☐ 4. Viral Hepatitis C	☐ 19. Leprosy (Paucibacillary)	☐ 34. Tuberculosis - PTB Smear Positive
☐ 5. Viral Hepatitis *(Others)*	☐ 20. Leptospirosis	☐ 35. Tuberculosis - PTB Smear Negative
☐ 6. AIDS	☐ 21. Malaria - Vivax	☐ 36. Tuberculosis - Extra Pulmonary
☐ 7. Chancroid	☐ 22. Malaria - Falciparum	☐ 37. Typhoid - Salmonella typhi
☐ 8. Cholera	☐ 23. Malaria - Malariae	☐ 38. Typhoid - Paratyphoid
☐ 9. Dengue Fever	☐ 24. Malaria - Others	☐ 39. Viral Encephalitis - Japanese
☐ 10. Dengue Haemorrhagic Fever	☐ 25. Measles	☐ 40. Viral Encephalitis - Nipah
☐ 11. Diphtheria	☐ 26. Plague	☐ 41. Viral Encephalitis - (Others)
☐ 12. Dysentery	☐ 27. Rabies	☐ 42. Whooping Cough / Pertussis
☐ 13. Ebola	☐ 28. Relapsing Fever	☐ 43. Yellow Fever
☐ 14. Food Poisoning	☐ 29. Syphilis - Congenital	☐ 44. Others: please specify: _____
☐ 15. Gonorrhoea	☐ 30. Syphilis - Acquired	

Selain dari notifikasi bertulis, penyakit berikut perlu dinotifikasi melalui telefon dalam tempoh 24 jam iaitu:- Acute Poliomyelitis, Cholera, Dengue, Diptheria, Ebola, Food Poisoning, Plague, Rabies dan Yellow Fever

11. Cara Pengesanan Kes:
☐ Kes ☐ Kontak ☐ FOMEMA *
☐ Ujian Saringan _____

12. Status Pesakit:
☐ Hidup
☐ Mati - -

13. Tarikh Onset: - -

14. Ujian Makmal:
Nama Ujian: (i)_____
(ii)_____ (iii)_____
Tarikh Sampel Diambil: - -

15. Keputusan Ujian Makmal:
☐ Positif (_____)
☐ Negatif
☐ Belum Siap

16. Status Diagnosis:
☐ Sementara *(Provisional/Suspected)*
☐ Disahkan *(Confirmed)*
Tarikh Diagnosis - -

17. Maklumat Klinikal Yang Relevan:

18. Komen:

C. MAKLUMAT PEMBERITAHU

19. Nama Pengamal Perubatan:

20. Nama Hospital / Klinik dan Alamat:

21. Tarikh Pemberitahuan: - -

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Tandatangan
Pengamal Perubatan

SCHEDULE
(Regulation 2)
Form
(Regulation 2)
PREVENTION AND CONTROL OF INFECTIOUS DISEASES ACT 1988
PREVENTION AND CONTROL OF INFECTIOUS DISEASES (NOTICE FORM) (AMENDMENT) REGULATIONS 2011

Notification Form: Rev/2010
Serial No:

NOTIFICATION OF COMMUNICABLE DISEASES TO BE REPORTED

(Section 10, Prevention And Control Of Communicable Diseases Act, 1988)

A. PATIENT INFORMATION

1. Full Name (CAPITAL LETTER):

Accompany by(Mother/Father/Guardian):
(If under age/without Identity Card)

2. Identity Card Number / Travelling Document: ☐ Self ☐ Accompany by
(For Non Citizen)

Hospital/Clinic Reg. Number: Ward:_____ Date of Admission: ☐☐ / ☐☐ / ☐☐☐☐

3. Citizenship:
Citizen
☐ Yes Race/Ethnic:
Sub Ethnic:
(For Aborigines, Native of Sabah/Sarawak)
☐ No Country of origin:
Status of Entry: ☐ Legal ☐ Illegal ☐ Permanent Resident

4. Gender: ☐ Male ☐ Female

5. Date of birth: ☐☐ / ☐☐ / ☐☐☐☐

6. Age: ☐☐☐ ☐ Year ☐ Month ☐ Day

7. Occupation:_____
(If unemployed, please state self reference)

8. Telephone No.: ☐ Resident ☐ H.phone ☐ Office ☐☐☐ - ☐☐☐☐☐☐☐
(Contact purposes)

9. Current Address:

10. Address of Employer/School/College/University:

B. DISEASE DIAGNOSIS

☐ 1. Poliomyelitis	☐ 16. Hand, Food and Mouth Disease	☐ 31. Tetanus Neonatorum
☐ 2. Viral Hepatitis A	☐ 17. Human Immunodeficiency Virus Infection	☐ 32. Tetanus (Others)
☐ 3. Viral Hepatitis B	☐ 18. Leprosy (Multibacillary)	☐ 33. Typhus - Scrub
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☐ 11. Diphtheria	☐ 26. Plague	☐ 41. Viral Encephalitis - (Others)
☐ 12. Dysentery	☐ 27. Rabies	☐ 42. Whooping Cough / Pertussis
☐ 13. Ebola	☐ 28. Relapsing Fever	☐ 43. Yellow Fever
☐ 14. Food Poisoning	☐ 29. Syphilis - Congenital	☐ 44. Others: please specify: _____
☐ 15. Gonorrhoea	☐ 30. Syphilis - Acquired	

Besides by written notification, the following diseases must be notified by telephone within 24 hours, such as:- Acute Poliomyelitis, Cholera, Dengue, Diptheria, Ebola, Food Poisoning, Plague, Rabies and Yellow Fever.

11. Case detection classification:
☐ Case ☐ Contact ☐ FOMEMA
☐ Screening Test _____

12. Status of patient:
☐ Live/alive
☐ Died ☐☐ - ☐☐ - ☐☐☐☐

13. Date of Onset: ☐☐ - ☐☐ - ☐☐☐☐

14. Laboratory investigation:
Investigation: (i)_____
(ii)_____ (iii)_____
Date of specimen taken: ☐☐ - ☐☐ - ☐☐☐☐

15. Laboratory investigation result:
☐ Positive (_____)
☐ Negative
☐ Pending

16. Diagnosis Status:
☐ Provisional/Suspected
☐ Confirmed
Date of Diagnosis ☐☐ - ☐☐ - ☐☐☐☐

17. Relevant Clinical Information:

18. Comment:

C. NOTIFIER

19. Name of Medical Practitioner:

20. Name and address of Hospital/Clinic:

21. Date of Notification: ☐☐ - ☐☐ - ☐☐☐☐

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Signature of Medical Practitioner