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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| THIS FORM IS FOR GENERAL NOTIFICATION OF A DISEASE OR ILLNESS | | | | | | | | | | | | | | |
| **Notification Details** | General Practitioner | | | | | | Hospital Practitioner | | | | | | Other | |
| **NAME OF DISEASE** | **Please specify** | | | | | | | | | | | | | |
| **Name of person notifying** | **Add name** | | | | | | | | | | **Date reported** | | **Click for date** | |
| **Organisation** | **Enter organization name** | | | | | | | | | | **Phone** | | **Organisation phone** | |
| **Usual GP & Practice** | **GP name** | | | | | | | | | | **GP Phone** | | **GP phone** | |
| **Patient details and risk factors** | | | | | | | | | | | | | | |
| **Name of case** | **Surname** | | | | | | | **Given name(s)** | | | | | | |
| **NHI Number** | **Add NHI #** | | | | **Date of birth** | | | **Add DOB** | | | | **Gender** | | **Select from list** |
| **Address** | **Add address** | | | | | | | | | | | | | |
| **Email address** | **Add email** | | | | | | | | | | | | | |
| **Phone (home)** | **Add phone #** | | | | **Phone (work)** | | | | **Add alt #** | | | **Mobile** | | **Add mobile #** |
| **Ethnicity** | **Choose an item** | | | | | | | | | **Other, please specify** | | | | |
| **Occupation** | **Please specify** | | | | | | | | | | | | | |
| **Employer** | **Please specify** | | | | | | | | | | | | | |
| **Attends/works at ELS or School:** | Yes | | No | | | **If Yes, name & area of facility:**  **Add name and area** | | | | | | | | |
| **Hospitalised:** | Yes | | | No | | **Choose an item**. | | | | | | | | |
| **Pregnant** | Yes | | | No | | | | | | | | | | |
| **BASIS OF DIAGNOSIS** | | | | | | | | | | | | | | |
| **Symptoms** | | **Please specify** | | | | | | | | | | | | |
| **Onset date of symptoms** | | **Select date** | | | | | | | | | | | | |
| **Medication / Prescription** | | **Add comments here** | | | | | | | | | | | | |
| **CLINICAL MANAGEMENT** | | | | | | | | | | | | | | |
| **Laboratory confirmation of disease** | | Yes | No | | | **If yes, please specify** | | | | | | | | |
| **Isolation advice  (if appropriate)** | | Yes | No | | | **Isolation start date** | | | | | | | | |
| **ADDITIONAL COMMENTS**  **E.g. Known high risk contacts, suspected source of infection or significant exposure events** | | | | | | | | | | | | | | |
| **Add comments here** | | | | | | | | | | | | | | |

**Thank you for completing this form. You may be contacted by ARPHS for further information.   
Email ARPHS at** [**notify@adhb.govt.nz**](mailto:notify@adhb.govt.nz)