Ministry of Health
Epidemiology and Surveillance Unit

Date of Notification: _____

Notified by: _____

Case Report

GENERAL INFORMATION

Patient's Name: _____

Birth Date: ___|___|___ Age: _____ Sex: ☐ Male ☐ Female

Address: _____

Telephone: Home: _____ Work: _____ E-Mail: _____

Occupation: _____

Current Status: ☐ Inpatient ☐ Outpatient ☐ Deceased Date: _____

CLINICAL DIAGNOSIS

Gastroenteritis:	☐ Salmonella	☐ Shigella	☐ Other _____
Hepatitis:	☐ Type A	☐ Type B	☐ Type NANB
Meningitis:	☐ Bacterial	☐ Non-bacterial	
Tuberculosis:	☐ Pulmonary	☐ Other	
STD:	☐ Gonorrhea	☐ Syphilis	☐ Other _____

Other: _____

LABORATORY DATA

Pathogen: _____ ☐ Negative ☐ Positive

Other: _____

ADDITIONAL COMMENTS

_____

_____

_____

_____

Doctor to contact for additional information:

_____

Date: _____ Signature: _____

For Ministry of Health Use Only

Action

- ☐ Follow-up
- ☐ Health Education
- ☐ Referral _____
- ☐ Culture
- ☐ X-Ray

Notes

Date: _____ Signature: _____