Restricted

FORM 2

PREVENTION AND CONTROL OF DISEASE ORDINANCE

(Cap. 599)

Notification of Infectious Diseases other than Tuberculosis

Particulars of Infected Person

Name in English:	Name in Chinese:	Age / Sex:	I.D. Card / Passport No.:
Residential address:			Telephone No. (Home): (Mobile): (Office / school / others):
Name and address of workplace / school:			
Job title / Class attended:			
Hospital / Clinic sent to (if any):			Hospital / A&E No.:

Disease ["✓"] below Suspected / Confirmed on _____ / _____ / _____ (Date: dd/mm/yyyy)

☐ Acute poliomyelitis	☐ *Haemophilus influenzae* type b infection (invasive)	☐ Relapsing fever
☐ Amoebic dysentery	☐ Hantavirus infection	☐ Rubella and congenital rubella syndrome
☐ Anthrax	☐ Invasive pneumococcal disease	☐ Scarlet fever
☐ Bacillary dysentery	☐ Japanese encephalitis	☐ Severe Acute Respiratory Syndrome
☐ Botulism	☐ Legionnaires' disease	☐ Shiga toxin-producing *Escherichia coli* infection
☐ Chickenpox	☐ Leprosy	☐ Smallpox
☐ Chikungunya fever	☐ Leptospirosis	☐ *Streptococcus suis* infection
☐ Cholera	☐ Listeriosis	☐ Tetanus
☐ Community-associated methicillin-resistant *Staphylococcus aureus* infection	☐ Malaria	☐ Typhoid fever
☐ Coronavirus disease 2019 (COVID-19)	☐ Measles	☐ Typhus and other rickettsial diseases
☐ Creutzfeldt-Jakob disease	☐ Melioidosis	☐ Viral haemorrhagic fever
☐ Dengue fever	☐ Meningococcal infection (invasive)	☐ Viral hepatitis
☐ Diphtheria	☐ Middle East Respiratory Syndrome	☐ West Nile Virus Infection
☐ Enterovirus 71 infection	☐ Mpox*	☐ Whooping cough
☐ Food poisoning	☐ Mumps	☐ Yellow fever
Number of persons known to be affected: ____	☐ Novel influenza A infection	☐ Zika Virus Infection
Place and district of consumption (e.g. "XX Restaurant in Mongkok"):_____	☐ Paratyphoid fever	
_____	☐ Plague	
_____	☐ Psittacosis	
Date of consumption: _____	☐ Q fever	
	☐ Rabies	

* Corresponding to monkeypox as specified in Schedule 1 under Cap. 599.

Notified under the Prevention and Control of Disease Regulation by

Dr. _____ of _____Hospital / Clinic / Private Practice
(Full Name in BLOCK Letters)

_____Ward / Unit / Specialty on _____ / _____ / _____ (Date: dd/mm/yyyy)

Telephone No.: _____ Fax No.: _____ _____
(Signature)

Remarks: