<u>Restricted</u>

REPORT TO DEPARTMENT OF HEALTH ON POISONING OR COMMUNICABLE DISEASES OTHER THAN THOSE SPECIFIED IN THE PREVENTION AND CONTROL OF DISEASE ORDINANCE

(CENTRAL NOTIFICATION OFFICE, CENTRE FOR HEALTH PROTECTION)

(FAX: 2477 2770; TEL: 2477 2772)

PARTICULARS OF AFFECTED PERSON

Name in English:	Name in Chinese:	Age/Sex:	I.D. Card/Passport No.:
Residential address:			Telephone Number: (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 _____/ _____ / ______.(dd/mm/yyyy)

☐ **Suspected Outbreak**

Please specify the nature of outbreak: ________________________________

Number of persons affected: ________________________________

☐ **Infectious Disease** that is rare, severe or important (e.g. acute flaccid paralysis, *Vibrio vulnificus* infection, paediatric invasive pneumococcal disease etc.)

Please specify: ________________________________

(Please attach the paediatric invasive pneumococcal disease (IPD) case report form when reporting paediatric invasive pneumococcal disease)

☐ **Chinese medicine-related Adverse Event**

Please specify: ________________________________

(Please attach supplementary form for reporting Chinese medicine-related adverse events)

☐ **Heavy Metal Poisoning**

Please specify: ________________________________

☐ **Other Poisoning**

Please specify: ________________________________

Remark: For occupational infection or poisoning specified in Schedule 2 of the Occupational Safety and Health Ordinance, please notify Labour Department as appropriate. Details can be found on the website http://www.labour.gov.hk

Reported 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:

Supplementary Form for Reporting Chinese medicine-related Adverse Events

From: ____________________________ Tel no.: _________________

To: Central Notification Office, Centre for Health Protection, Department of Health

Fax: 2477 2770 (Tel: 2477 2772)

Part I Clinical history of patient

Presenting symptoms with date of onset:
Relevant medical history:
Relevant drug history:
Investigation(s) done and results (please provide a copy of relevant laboratory results):
Treatment given and current condition:
Follow up plan:

Part II Details of Incriminated Chinese Medicine (CM)

Name of CM in English:	Name of CM in Chinese:
Active ingredients of the CM (if known):	
Supposed indication for use:	Any people with same exposure: Y/N If yes, please provide name(s) and tel. nos.:
Dosage, preparation method and duration of consumption (please ***fax the prescription sheet*** and details of preparation together with this form if available):	
Any remnants or raw herbs collected from the patient? Y/N (Please note that **DH will analyse the contents of the remnants and raw herbs** if available.)	
Laboratory tests done on the herbs (if any) and results (please provide a copy of relevant laboratory results):	
Is the CM prescribed by a listed / registered CM practitioner? Y / N Name and address of CM practitioner whom the patient consulted:	
Name of herbal shop (if not dispensed by CM practitioner):	Address of herbal shop:

Please fill in this form for each reported case and return the completed form to the Central Notification Office (CENO) of CHP.
(Fax number: 2477 2770 or email: diseases@dh.gov.hk)

Paediatric invasive pneumococcal disease (IPD)
Case report form (for patients under 18 years old)

A. Notification Information			
Notifying Doctor		Organisation	
Telephone		Date of reporting (DD/MM/YYYY)	

B. Demographics			
PLEASE AFFIX PATIENT'S GUM LABEL IF APPLICABLE			
1. Name		2a. ID number 2b. HN number	
3. Date of birth (DD/MM/YYYY)		4. Age (year)	
5. Sex	M/F	6. Ethnicity	
7. Usual place of residence	Hong Kong/ Mainland China/ Others: ________________(please specify)/ Unknown		
8. Travel history within 14 days before symptom onset	Y/N/ Unknown; If Y, please specify ______________________________		
9a. Institutional care	Y/N	9b. Name of institution	
10. Residential address (including institution)			

11a. Hospital		11b. Ward		11c. Date of admission (DD/MM/YYYY)	

C. Pneumococcal Vaccination History		
Pneumococcal Conjugate Vaccine Y/ N/ Unknown		
Specify **type for each dose** of vaccine and **date** of administration or attach copy of immunisation record		
No. of dose	Type of Pneumococcal Vaccine*	Date (DD/MM/YYYY)
1st		
2nd		
3rd		
4th		
5th		
6th		
* a = PCV7; b = PCV10; c = PCV13; d = PCV – exact valency unsure		
Pneumococcal Polysaccharide Vaccine (23vPPV) Y/ N/ Unknown Date of vaccination (DD/MM/YYYY):		

D. Underlying Disease		**Please specify**
1. CVS	Y/N	
2. CNS	Y/N	
3. Metabolic	Y/N	
4. Respiratory	Y/N	
5. Malignancy	Y/N	
6. Haematologic	Y/N	
7. Prematurity	Y/N	
8. Immunodeficiency	Y/N	
9. Others	Y/N	

E. Clinical Details			
Onset date (fever) (DD/MM/YYYY)		Type of pneumococcal disease (Please circle)	Bacteremia alone Meningitis Pneumonia Bacteremic otitis media Others (specify):
Suppurative complications	Y/N	Pleural empyema/Subdural empyema Others:	
HUS	Y/N	Remarks:	
Other complications			
Known concurrent infection (with laboratory confirmation)		Influenza: Y/ N/ Unknown Others: Y/N ________________________(please specify)	

F. Treatment and Outcome (as of date of reporting)			
1. Antibiotic used	Route	Dosage / kg	Start date – End date (DD/MM/YYYY – DD/MM/YYYY)
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
______________	______________	______________	______________
2a. ICU admission	Y/N	2b. Duration of stay	
3a. Mechanical ventilation	Y/N	3b.Duration of ventilation	
4a. Renal replacement therapy (e.g. renal dialysis, hemodialysis)	Y/N	4b. Duration	
5a.Surgical procedure(s)	Y/N	5b. Specify	Chest drain/ neurosurgical procedure/Others:
6.Date of discharge (DD/MM/YYYY)		7. Date of death (DD/MM/YYYY)	Y/N (/ /)
8a. Known sequelae at time of discharge	Y/N	8b.Specify	

G. Microbiology Data				
Laboratory criteria: either culture or nucleic acid test for *Streptococcus pneumoniae* is positive from a normally sterile site.				
Specimen type tested **positive**	Test type	Date of collection (DD/MM/YYYY)	**TO BE COMPLETED BY CHP**	
			Serotype	Laboratory reference number
Blood/ CSF/ pleural fluid/ joint fluid/ other normally sterile site (please specify) ______________________	Culture/ PCR			
Blood/ CSF/ pleural fluid/ joint fluid/ other normally sterile site (please specify) ______________________	Culture/ PCR			