

Restricted

**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:
Name and address of workplace/ school:			(Home):
Job title/ Class attended:			(Mobile):
Hospital/ Clinic sent to (if any) :			(Office/ school/ others):
			Hospital/A&E No.:

Disease ["✓"] below Suspected/Confirmed on ____/____/____.(dd/mm/yyyy)

<input type="checkbox"/> Suspected Outbreak Please specify the nature of outbreak: _____ Number of persons affected: _____
<input type="checkbox"/> Infectious Disease that is rare, severe or important (e.g. acute flaccid paralysis, <i>Vibrio vulnificus</i> infection etc.) Please specify: _____
<input type="checkbox"/> Chinese medicine-related Adverse Event Please specify: _____ (Please attach supplementary form for reporting Chinese medicine-related adverse events)
<input type="checkbox"/> Heavy Metal Poisoning Please specify: _____
<input type="checkbox"/> 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 <i>fax the prescription sheet</i> 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: