<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 with necrotising fasciitis, etc.)

Please specify: ____

□ **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)

<table>
<tr><td>Name of CM in English:</td><td>Name of CM in Chinese:</td></tr>
<tr><td colspan="2">Active ingredients of the CM (if known):</td></tr>
<tr><td>Supposed indication for use:</td><td>Any people with same exposure: Y/N
If yes, please provide name(s) and tel. nos.:</td></tr>
<tr><td colspan="2">Dosage, preparation method and duration of consumption (please fax the prescription sheet and details of preparation together with this form if available):</td></tr>
<tr><td colspan="2">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.)</td></tr>
<tr><td colspan="2">Laboratory tests done on the herbs (if any) and results (please provide a copy of relevant laboratory results):</td></tr>
<tr><td colspan="2">Is the CM prescribed by a listed / registered CM practitioner? Y/N
Name and address of CM practitioner whom the patient consulted:</td></tr>
<tr><td>Name of herbal shop (if not dispensed by CM practitioner):</td><td>Address of herbal shop:</td></tr>
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