



**NOTIFICATION FORM  
FOR INFLUENZA A(H1N1) CASE**  
Disease Control Division  
Ministry Of Health Malaysia

For Disease Control  
Division use only  
ID No:

<b>1. Reporting Centre</b>		<b>Name of Hospital / Clinic:</b>		<b>State:</b>	
Phone		Fax:		E-mail:	
<b>2. Information of Patient</b>		<b>Name:</b>		<b>Age:</b> ___yr ___mth	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Address:</b>			<b>Phone (Home):</b>		<b>RN No:</b>
Nationality: <input type="checkbox"/> Malaysian <input type="checkbox"/> Non Malaysian		<b>Ethnicity:</b> <input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other, specify:			IC No:
Country of Origin:			Passport No:		
<b>Occupation</b> : <input type="checkbox"/> Health Care worker <input type="checkbox"/> Pig Farmer <input type="checkbox"/> Others, please state:				<b>Date of symptom onset</b> [dd/mm/yy] :	
<b>3. Signs and Symptoms</b>		<input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Sorethroat <input type="checkbox"/> Myalgia <input type="checkbox"/> Headache		<input type="checkbox"/> Shortness of breath/difficulty breathing	
		Temperature on admission: ____°C		<input type="checkbox"/> Other symptoms, specify :	
<b>4. Chest X-Ray finding</b>		Evidence of lung infiltrates consistent with pneumonia		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	
<b>5. Is there any alternative diagnosis that can fully explain patient's illness?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6. Clinical status at time of report</b>		Was patient hospitalised? <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> Brought In Dead (BID) Date: ____		Ward: <input type="checkbox"/> Isolation Ward <input type="checkbox"/> ICU	Progress: <input type="checkbox"/> On treatment, specify: _____ <input type="checkbox"/> Died Date : ____
If patient died: Was past mortem performed?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending			
<b>7. Exposure History</b>	Did patient had history of close contact with Influenza A(H1N1) patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please state the name and address	Name: Address:	
<b>8. Travel History</b>	History of recent travel to area(s) with reported transmission of influenza A(H1N1)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify the area:				
	Country/State/province visited	Duration of stay		Name of Airline & Flight No/Cruise/Other mode of transportation	
		From[dd/mm/yr]	To[dd/mm/yr]		
1					
2					
3					
Date of return to Malaysia:			Entry point :		
<b>9. Similar illness</b>		Anybody in the neighbourhood having similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>10. Diagnostic Evaluation</b>		Date taken	Date send to lab	Name of laboratory	Result
Virology					
<b>11. Working diagnosis: (please state)</b>					
<b>12. Reporting Officer:</b>				Signature:	
Designation:			Date:	H/phone No:	
<b>For District Health Office use only</b>					
<b>13. Contact Tracing</b>		Has contact tracing been done? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of contact tracing done: Number of contacts examined:		Number of contact with similar illness: Number of contact quarantined: Number of contact referred to hospital:	
<b>14. Active case finding</b>		Has active case finding been initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of people with similar illness:		No. of cases referred to hospital: Number of cases quarantined:	
<b>15. Investigating Officer:</b>				Signature:	
Designation:			Date:	H/Phone No:	
<b>For Disease Control Division use only</b>					
<b>COMMENTS:</b>					

**NOTE:** Please fax this form within 24 hours to the nearest District Health Office and the Crisis Preparedness & Response Centre (CPRC), MOH