National Surveillance Unit, National Epidemiology Branch,
ARC Building, 15 Knutsford Boulevard, 2nd Floor, Kingston 5, St. Andrew
Email: surveillance@moh.gov.jm, Telephone 876-633-7937

The General Class 1 – Individual Notification Form

INITIAL DIAGNOSIS

Initial Diagnosis/Notification:

Date of Notification: *DD/MM/YYYY*	Date Patient Seen: *DD/MM/YYYY*	Case type: ◯ New Case ◯ Follow-up

Patient's Demographics

Patient's ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN		Patient's ID Number:
First Name:		Middle Name(s):
Last Name:		Pet Name(s):
Patient's Maiden Name (if applicable):		
Sex Assigned at Birth: ◯ Male ◯ Female	Date of Birth: *DD/MM/YYYY*	Age:
Name of Facility Where Patient Seen:		Medical Record Number:
Country of Residence:	Community:	Parish (Jamaica):
House Number, Street Name:		
Landmark or directions to address:		
Phone Number:	Email Address:	Occupation:
Name of Workplace/School:		
Address of Workplace/School:		

Has the patient travelled overseas in the last 6 weeks? ◯ Yes ◯ No ***If yes, fill out the table below:***

Country Visited	City Visited	Date Arrived in Country	Date Departed Country
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*
		DD/MM/YYYY	*DD/MM/YYYY*

Date returned to Jamaica *DD/MM/YYYY*

Next of Kin

First Name:	Last Name:	Pet Name(s):
NOK ID Type: ◯ Driver's License ◯ TRN ◯ Passport ◯ NIN		NOK ID Number:
Address: Lot/ Street/Community/Parish:		
Name of School/ Workplace:		
Address of School/Workplace:		
Phone number:		Email address:

Relationship to the Patient:

◯ Wife	◯ Son	◯ Uncle	◯ Cousin
◯ Husband	◯ Daughter	◯ Aunt	◯ Friend
◯ Mother	◯ Sister	◯ Grandmother	◯ Guardian
◯ Father	◯ Brother	◯ Grandfather	◯ Other (specify):

Clinical Profile of Patient

Has the patient experienced/Is the patient experiencing any of the following symptoms?

SYMPTOM	DATE OF ONSET	DURATION	SYPMPTOM	DATE OF ONSET	DURATION
◯ No Symptoms	*DD/MM/YYYY*		◯ Jaundice	*DD/MM/YYYY*	
◯ Abdominal Pain	*DD/MM/YYYY*		◯ Joint Pain	*DD/MM/YYYY*	
◯ Conjunctivitis	*DD/MM/YYYY*		◯ Myalgia	*DD/MM/YYYY*	
◯ Cough	*DD/MM/YYYY*		◯ Rash	*DD/MM/YYYY*	
◯ Diarrhoea	*DD/MM/YYYY*		◯ Seizures	*DD/MM/YYYY*	
◯ Eye Pain	*DD/MM/YYYY*		◯ Vomiting	*DD/MM/YYYY*	
◯ Fever	*DD/MM/YYYY*		◯ Weakness	*DD/MM/YYYY*	
◯ Haemoptysis	*DD/MM/YYYY*		◯ Other	*DD/MM/YYYY*	
◯ Headache	*DD/MM/YYYY*		Specify Other:		

Patient's Name: Medical Record Number:

Does the patient have any pre-existing conditions? ◯ Yes ◯ No ◯ Unknown

Please specify any pre-existing conditions

◯ Asthma	◯ Diabetes mellitus	◯ HIV/AIDS	◯ Malignancy
◯ Autoimmune	◯ Heart disease	◯ Hypertension	◯ Sickle cell disease
◯ Chronic obstructive pulmonary disease (COPD)	◯ Kidney disease	◯ Liver dysfunction	◯ Other Specify Other:

Vaccination Status:

Type of Vaccine	Number of doses	Date of last dose	Source of Vaccination Information **(Vaccination card, Health service record, Verbal)**
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

Was patient admitted to hospital? ◯ Yes ◯ No	If yes, date of admission *DD/MM/YYYY*
Name of hospital:	Ward:
Was patient discharged from hospital? ◯ Yes ◯ No	If yes, date discharged *DD/MM/YYYY*
Is patient deceased? ◯ Yes ◯ No	If yes, date of death *DD/MM/YYYY*

Sample and Lab Information

Was a sample taken? ◯ Yes ◯ No

If yes, what specimen was taken?

◯ CSF	◯ Nasopharyngeal Swab	◯ Sputum	◯ Tissue
◯ Blood Smear	◯ Naso-/Oro-/ Pharyngeal Swab	◯ Stool	◯ Other (specify):
◯ EDTA Blood	◯ Serum	◯ Urine	

What date was the specimen taken? *DD/MM/YYYY*

Which lab is the sample being sent to?

◯ National Public Health Laboratory ◯ University of the West Indies ◯ Other

Specify Other Laboratory:

Lab Test(s) Requested:

◯ Antigen	◯ PCR	◯ Culture	◯ Microscopy
◯ ELISA	◯ Western Blot	◯ Other (specify):	

Lab result(s): ◯ Positive ◯ Negative ◯ Indeterminate

Notifier's Comments:

Notifier's Details

Date of Reporting *(DD/MM/YYYY)*:

First Name:	Last Name
Professional Group:	
Phone number:	Email Address:
Name of Institution:	
Office Number/Street Name:	
Community:	Parish:

Health Region: ◯ SERHA ◯ NERHA ◯ SRHA ◯ WRHA

Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): *DD/MM/YYYY*