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| Notifiable Disease Notification Form (for GP use) | | | | | | | | | | |
| To | **Te Mana Ora | Community and Public Health**  [**CW-NPHS-HealthProtection@tewhatuora.govt.nz**](mailto:CW-NPHS-HealthProtection@tewhatuora.govt.nz) | | | | | Attention | **Medical Officer of Health** | | Date |  |
| Region  (select one of the following) | | | Waitaha | Canterbury  South Canterbury  Te Tai o Poutini | West Coast | | | | | | | |
| **CAUTION:** Kia ora. This information is **legally privileged and confidential**. If you have received this message in error, please forward to the above destination without delay. If the reader of this message is not the intended recipient you are hereby notified that any use, dissemination, distribution or reproduction of this message is prohibited. Failure to comply with this caution could result in legal action. Ngā mihi / thank you. | | | | | | | | | | |
| **DISEASE:** | | …………………………………………………………………………………………………………………………………………………………………………….……………… | | | | | | | | |
| **Case identification** *(affix label below or give details)* | | | | | | | | | | |
| Surname: …………………………………………………………………………………………  First names: ………………………………………………………………………….…………  Address: ……………………………………….………..……………………………………..…  Suburb/City: …………………………………………………..…………………….…………… | | | | | | | | **Phone:**  Home: (…) ………………..………  Work: (…) .……….…………….…  Mobile: (…) ……….………...…… | | |
| Date of birth: ……….……/……….……/.......……  [or age years]  NHI: ……………………………………………………….. | | | | **Gender/Sex**  Male  Female  Other | Ethnicity: (tick all that apply)  NZ Māori  NZ Pakeha / European  Other European  Pacific Islander  Other (specify): ……………………………………………………………… | | | | | |
| **Case demography** | | | | | | | | | | |
| Occupation: ……………………………………………………………………………..………………………………………  Place of work/school/preschool: ………………………………………………………………..……….……………………  Recent overseas travel?  Yes  No If yes; where? ………………………………………………………..  …………………………………………………………………………………………………………………………….……..  Onset date: …………/…………/……..…… Has patient been informed?  Yes  No  Suspected cause of infection (if known): ……………………………………………………… ………..…………………  Additional information: ……………………………………………………………………………………………………….. | | | | | | | | | | |
| **Notifier identification** | | | | | | | | | | |
| Doctor's name *(print)*: ……………………………………..……… Email: ………………………………………….………..  Contact phone: …………………………………………………………….…… Extension: …………..…………..….….…  Surgery name and address: ………………………………………………………………………………………….…………  (Surgery stamp)  Medical Laboratory used  Canterbury Health  Southern Community  Other ………………………………………………………………………….……..… | | | | | | | | | | |