

## Notifiable Disease Notification Form (for GP use)

To	<b>Te Mana Ora (Community and Public Health)</b>	Attention	<b>Medical Officer of Health</b>	Date	
Email (select one of the following)	<input type="checkbox"/> Waitaha   Canterbury <input type="checkbox"/> South Canterbury <input type="checkbox"/> Te Tai o Poutini   West Coast	<a href="mailto:CPHHealthProtection@cdhb.health.nz">CPHHealthProtection@cdhb.health.nz</a> <a href="mailto:CPHcallsouthcanterbury@cdhb.health.nz">CPHcallsouthcanterbury@cdhb.health.nz</a> <a href="mailto:HATWestCoast@cdhb.health.nz">HATWestCoast@cdhb.health.nz</a>			
<b>CAUTION:</b> Kia ora. This information is <b>legally privileged and confidential</b> . 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.					
<b>DISEASE:</b> .....					
<b>Case identification</b> (affix label below or give details)					
Surname: ..... First names: ..... Address: ..... Suburb/City: .....				<b>Phone:</b> Home: (...) ..... Work: (...) ..... Mobile: (...) .....	
Date of birth: ...../...../..... [or age          years] NHI: .....	<b>Gender/Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<b>Ethnicity:</b> (tick all that apply) <input type="checkbox"/> NZ Māori <input type="checkbox"/> NZ Pakeha / European <input type="checkbox"/> Other European <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other (specify): .....			
<b>Case demography</b>					
Occupation: ..... Place of work/school/preschool: ..... Recent overseas travel? <input type="checkbox"/> Yes <input type="checkbox"/> No              If yes; where? ..... ..... Onset date: ...../...../.....              Has patient been informed? <input type="checkbox"/> Yes <input type="checkbox"/> No Suspected cause of infection (if known): ..... Additional information: .....					
<b>Notifier identification</b>					
Doctor's name (print): ..... Email: ..... Contact phone: ..... Extension: ..... Surgery name and address: ..... (Surgery stamp) Medical Laboratory used <input type="checkbox"/> Canterbury Health <input type="checkbox"/> Southern Community <input type="checkbox"/> Other .....					