



**NOTIFICATION FORM
FOR ACUTE HEPATITIS OF UNKNOWN AETIOLOGY**

Disease Control Division
Ministry Of Health Malaysia

1. Reporting Centre		Name of Hospital / Clinic:		State:	
Phone:		Fax:		E-mail:	
Information of Patient		Name:		Age: ___yr ___mth	Gender: ☐ Male ☐ Female
Address:			Phone (Home):		RN No:
Nationality:		Ethnicity: ☐ Malay ☐ Chinese ☐ Indian ☐ Other, specify:			IC No:
☐ Malaysian ☐ Non Malaysian		Country of Origin:			Passport No:
Student : ☐ Yes. If yes, please state name of institution: ☐ No					Date of symptom onset [dd/mm/yy] :
3. Signs and Symptoms		☐ jaundice Other symptoms of acute hepatitis: ☐ Vomiting ☐ Malaise ☐ Right upper quadrant pain ☐ Dark coloured urine ☐ Nausea ☐ Anorexia ☐ Extreme fatigue ☐ *Other symptoms, specify :			
4. Patient ever been positive COVID-19?		Past Infection ☐ Yes, date positive: ☐ No Current Infection ☐ Yes, date positive: ☐ No			
5. Has the patient received COVID-19 vaccination?		☐ Yes. If yes, Type of vaccine: Comirnaty / Sinovac / others: How many doses: 1 dose / 2 doses / 3 doses. ☐ No			
6. Is there any alternative diagnosis that can fully explain patient's illness?		☐ Yes, please specify: ☐ No			
7. Clinical status at time of report		Was patient hospitalised?		Ward:	Progress:
		☐ Yes, date: ☐ No ☐ Brought in dead (RID)		☐ Isolation ward ☐ General ward ☐ ICU	☐ On treatment, specify: ☐ Died Date : ____
If patient died: Was past mortem performed?		☐ Yes ☐ No ☐ Pending			
8. Exposure History		Has patient in close contact with any jaundice case? ☐ Yes ☐ No If yes, please specify:			
9. Similar illness		Anybody in the neighbourhood having similar illness? ☐ Yes ☐ No			
10. Diagnostic Evaluation		Date taken	Result		
AST/ALT value					
Virology		Hepatitis A ☐ Positive ☐ Negative ☐ Pending Hepatitis B ☐ Positive ☐ Negative ☐ Pending Hepatitis C ☐ Positive ☐ Negative ☐ Pending Hepatitis D ☐ Positive ☐ Negative ☐ Pending Hepatitis E ☐ Positive ☐ Negative ☐ Pending Adenovirus ☐ Positive ☐ Negative ☐ Pending Other tests, please specify:			
11. Working diagnosis: (please state)					
12. Reporting Officer:				Signature:	
Designation:		Date:		H/phone No:	
For State Health Department use only					
13. Name of receiving officer:				Signature:	
Designation:		Date:		H/Phone No:	
14. Date of notification to District Health Office:					
For Disease Control Division use only					
COMMENTS:					
Date of notification to State Health Department:					