

Appendix 3

KKM-syndssurv /2003.2

**SYNDROMIC NOTIFICATON FORM
DISEASE CONTROL DIVISION
MINISTRY OF HEALTH MALAYSIA
TEL: 03-88834327 FAX: 03-88836271**

Reporting A & E / Hospital:
Tel. No.: Fax No: E-mail :

Patient's Name :
Patient's Address:

IC No.: R/N No:(if applicable)
Age: Sex: Male / Female Ethnicity: M / C / I / Other
Please state:.....
Admission: ICU / Ward/ Mortuary. Date of adm: / /

Please tick the relevant box for the syndrome reported:

CLINICAL SYNDROMES		DATE OF ONSET [dd/mm/yr]
☐	Acute dermatological syndrome	
☐	Acute neurological syndrome	
☐	Acute respiratory syndrome	
☐	Acute haemorrhagic syndrome	
☐	Acute jaundice syndrome	
☐	Acute diarrhoeal syndrome	

Working diagnosis:

Has the patient been in a foreign country in the last three weeks?

☐ Yes

If yes please state the country (s):

☐ No

Name of Reporting Officer: Signature:

Designation: Date:

Note: Please fax this form within 24 hours to District Health Office. Thank you.