

**Restricted**

**FORM 2**

**PREVENTION AND CONTROL OF DISEASE ORDINANCE**

**(Cap. 599)**

**Notification of Infectious Diseases other than Tuberculosis**

**Particulars of Infected Person**

Name in English:	Name in Chinese:	Age / Sex:	I.D. Card / Passport No.:
Residential address:			Telephone No. (Home):
Name and address of workplace / school:			(Mobile):
Job title / Class attended:			(Office / school / others):
Hospital / Clinic sent to (if any):			Hospital / A&E No.:

Disease [“✓”] below Suspected / Confirmed on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Date: dd/mm/yyyy)

<input type="checkbox"/> Acute poliomyelitis <input type="checkbox"/> Amoebic dysentery <input type="checkbox"/> Anthrax <input type="checkbox"/> Bacillary dysentery <input type="checkbox"/> Botulism <input type="checkbox"/> Chickenpox <input type="checkbox"/> Chikungunya fever <input type="checkbox"/> Cholera <input type="checkbox"/> Community-associated methicillin-resistant <i>Staphylococcus aureus</i> infection <input type="checkbox"/> Coronavirus disease 2019 (COVID-19) <input type="checkbox"/> Creutzfeldt-Jakob disease <input type="checkbox"/> Dengue fever <input type="checkbox"/> Diphtheria <input type="checkbox"/> Enterovirus 71 infection <input type="checkbox"/> Food poisoning Number of persons known to be affected: ____ Place and district of consumption (e.g. “XX Restaurant in Mongkok”): ____ _____ Date of consumption: _____	<input type="checkbox"/> <i>Haemophilus influenzae</i> type b infection (invasive) <input type="checkbox"/> Hantavirus infection <input type="checkbox"/> Invasive pneumococcal disease <input type="checkbox"/> Japanese encephalitis <input type="checkbox"/> Legionnaires' disease <input type="checkbox"/> Leprosy <input type="checkbox"/> Leptospirosis <input type="checkbox"/> Listeriosis <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Melioidosis <input type="checkbox"/> Meningococcal infection (invasive) <input type="checkbox"/> Middle East Respiratory Syndrome <input type="checkbox"/> Mpox* <input type="checkbox"/> Mumps <input type="checkbox"/> Novel influenza A infection <input type="checkbox"/> Paratyphoid fever <input type="checkbox"/> Plague <input type="checkbox"/> Psittacosis <input type="checkbox"/> Q fever <input type="checkbox"/> Rabies	<input type="checkbox"/> Relapsing fever <input type="checkbox"/> Rubella and congenital rubella syndrome <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Severe Acute Respiratory Syndrome <input type="checkbox"/> Shiga toxin-producing <i>Escherichia coli</i> infection <input type="checkbox"/> Smallpox <input type="checkbox"/> <i>Streptococcus suis</i> infection <input type="checkbox"/> Tetanus <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Typhus and other rickettsial diseases <input type="checkbox"/> Viral haemorrhagic fever <input type="checkbox"/> Viral hepatitis <input type="checkbox"/> West Nile Virus Infection <input type="checkbox"/> Whooping cough <input type="checkbox"/> Yellow fever <input type="checkbox"/> Zika Virus Infection
---	--	---

\* Corresponding to monkeypox as specified in Schedule 1 under Cap. 599.

Notified under the Prevention and Control of Disease Regulation by

Dr. \_\_\_\_\_ of \_\_\_\_\_ Hospital / Clinic / Private Practice  
(Full Name in BLOCK Letters)

\_\_\_\_\_ Ward / Unit / Specialty on \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (Date: dd/mm/yyyy)

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
\_\_\_\_\_  
(Signature)

Remarks:
----------