Restricted

REPORT TO DEPARTMENT OF HEALTH ON POISONING OR COMMUNICABLE DISEASES OTHER THAN THOSE SPECIFIED IN THE PREVENTION AND CONTROL OF DISEASE ORDINANCE

(CENTRAL NOTIFICATION OFFICE, CENTRE FOR HEALTH PROTECTION)

(FAX: 2477 2770; TEL: 2477 2772)

PARTICULARS OF AFFECTED PERSON

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

Disease [" "] below Suspected/Confirmed on_____/_____/ _____.(dd/mm/yyyy)

□ **Suspected Outbreak**

Please specify the nature of outbreak: _____

Number of persons affected: _____

□ **Infectious Disease** that is rare, severe or important (e.g. acute flaccid paralysis, *Vibrio vulnificus* infection with necrotising fasciitis, etc.)

Please specify: _____

□ **Chinese medicine-related Adverse Event**

Please specify: _____

(Please attach supplementary form for reporting Chinese medicine-related adverse events)

□ **Heavy Metal Poisoning**

Please specify: _____

□ **Other Poisoning**

Please specify: _____

Remark: For occupational infection or poisoning specified in Schedule 2 of the Occupational Safety and Health Ordinance, please notify Labour Department as appropriate. Details can be found on the website http://www.labour.gov.hk

Reported 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:

Supplementary Form for Reporting
Chinese medicine-related Adverse Events

From: _____ Tel no.: _____

To: Central Notification Office, Centre for Health Protection, Department of Health

Fax: 2477 2770 (Tel: 2477 2772)

Part I Clinical history of patient

Presenting symptoms with date of onset:
Relevant medical history:
Relevant drug history:
Investigation(s) done and results (please provide a copy of relevant laboratory results):
Treatment given and current condition:
Follow up plan:

Part II Details of Incriminated Chinese Medicine (CM)

Name of CM in English:	Name of CM in Chinese:
Active ingredients of the CM (if known):	
Supposed indication for use:	Any people with same exposure: Y/N If yes, please provide name(s) and tel. nos.:
Dosage, preparation method and duration of consumption (please ***fax the prescription sheet*** and details of preparation together with this form if available):	
Any remnants or raw herbs collected from the patient? Y/N (Please note that **DH will analyse the contents of the remnants and raw herbs** if available.)	
Laboratory tests done on the herbs (if any) and results (please provide a copy of relevant laboratory results):	
Is the CM prescribed by a listed / registered CM practitioner? Y/N Name and address of CM practitioner whom the patient consulted:	
Name of herbal shop (if not dispensed by CM practitioner):	Address of herbal shop: