health
Department:
Health
REPUBLIC OF SOUTH AFRICA

# Enhanced COVID-19 Notifiable Medical Conditions (NMC) Notification Form

{Section 90 (1) (j), (k) and (w) of National Health Act, 2003 (Act no. 61 of 2003)}

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES
Division of the National Health Laboratory Service

This form must be **completed immediately** by the health care provider who diagnosed the condition. ***Please mark applicable areas with an X***

| | | | |
|---|---|---|---|
| Health facility name *(with provincial prefix)* | | Health facility contact number | Health district |
| Patient file/folder number | Patient HPRS-PRN | | Date of notification: y y y y - m m - d d |

## Patient demographics

| | |
|---|---|
| First name | |
| Surname | |
| RSA ID/Passport number | |
| Citizenship | |
| Ethnic group | Black African / Coloured / Indian/Asian / White / Other |
| Date of birth | y y y y - m m - d d |
| Age | Years / Months (If less than 1 year) / Days (if less than 1 month) |
| Gender | Male / Female / Self-defined |
| Contact number | Alternative contact number |

## Next of kin

| | |
|---|---|
| Name | |
| Surname | |
| Relationship to the patient | |
| Contact number | |

## Medical condition details

| | |
|---|---|
| Medical condition | *This form is for notifying COVID-19 case only* |
| Was the patient previously tested for COVID-19? | |
| | Yes (if repeat test) / No (if first test) / Unknown |
| Date of symptom onset | y y y y - m m - d d |
| Symptoms | Fever / Sore / Cough / Shortness of breath |
| | Myalgia/body aches / Diarrhea / Other |
| Case severity | Asymptomatic / Mild[1] / Moderate[2] / Severe[3] |
| Date of diagnosis | y y y y - m m - d d |
| Method of diagnosis | Clinical signs and symptoms ONLY / Laboratory confirmed |
| | Rapid test / X-Ray / Other |
| Source of PUI[4] | Field testing / Health facility / Healthcare professional |
| Name of source of PUI | |

## Patient residential address

*Street/dwelling unit/building/ERF number*
*Street name, building, location description*
*Sub-place, suburb, village, postal area*
*Town/city* *Post code:*

## Employer/educational institution address

*Institution name*
*Street name, building, location description*
*Sub-place, suburb, village, postal area*
*Town/city* Post code:
Contact number

## Occupation

Unemployed / Student / Healthcare worker
Health laboratory worker / Other (specify)

## Hospitalisation

| | |
|---|---|
| Admission status | *Outpatient* / *Inpatient* |
| Clinically required hospitalisation | *Yes* / *No* |
| Date of admission | y y y y - m m - d d |
| Level of care | General ward / High Care / ICU |
| If High Care/ICU | |
| Date entered High Care /ICU | y y y y - m m - d d |
| Date exited High Care/ ICU | y y y y - m m - d d |

## Oxygen requirements during hospitalisation

Room air / Nasal cannula oxygen
Mechanical ventilation
Start date: y y y y - m m - d d End: y y y y - m m - d d
ECMO[5]
Start date: y y y y - m m - d d End: y y y y - m m - d d

Patient received systemic antimicrobial treatment during hospital admission for a probable or confirmed healthcare-associated infection: Yes / No / Unknown

[1] **Mild - not requiring hospitalization for clinical reasons**
[2] **Moderate - requiring hospitalization**
[3] **Severe - requiring high care/ICU**
[4] **PUI - Person under investigation**
[5] **ECMO – Extracorporeal membrane oxygenation**

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health Department: Health REPUBLIC OF SOUTH AFRICA

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES Division of the National Health Laboratory Service

This form must be **completed immediately** by the health care provider who diagnosed the condition. ***Please mark applicable areas with an X***

| Underlying factors/comorbid conditions | | | | | | |
|---|---|---|---|---|---|---|
| HIV | Yes | | No | | Unknown | |
| TB | Yes | | No | | Unknown | |
| COPD[6] | Yes | | No | | Unknown | |
| Hypertension | Yes | | No | | Unknown | |
| Diabetes | Yes | | No | | Unknown | |
| Asthma | Yes | | No | | Unknown | |
| Obesity | Yes | | No | | Unknown | |
| Pregnancy | Yes | | No | | Unknown | |
| Cancer | Yes | | No | | Unknown | |
| Other | Yes | | No | | | |
| If other, | | | | | | |
| If TB, is patient on TB treatment | Yes | | No | | Unknown | |
| If yes, TB treatment start date | y y y y - m m - d d | | | | | |
| If living with HIV, is patient on ART? | Yes | | No | | Unknown | |
| If yes, is there viral suppression? | Yes | | No | | Unknown | |

| History of close physical contact with confirmed COVID-19 case in past 14 days | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Close physical contact with a known COVID-19 case | Yes | | No | | Unknown | | | |
| If yes, please indicate the contact setting | | | | | | | | |
| Quarantine Centre | | Healthcare setting | | Family setting | | Workplace | | |
| Other, specify | | | | | | | | |

| Hospital outcome | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Status | Discharged | | In hospital | | Transferred | | Died | | | |
| If discharged, date | y y y y - m m - d d | | | | | | | | | |
| If died, date | y y y y - m m - d d | | | | | | | | | |

| Outcome of patient cared for at home after 14 days of symptom onset/test date | | | | | |
|---|---|---|---|---|---|
| Alive, asymptomatic | | Alive, symptomatic | | Died | |

| Specimen details | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Was the specimen collected | Yes | | No | | | | | | | | | | | | | | | | |
| Date of collection | y | y | y | y | - | m | m | - | d | d | | | | | | | | | |
| Specimen barcode/lab number | | | | | | | | | | | | | | | | | | | |

| Travel history in the last 14 days | | | |
|---|---|---|---|
| Did patient travel outside of usual place of residence? | | Yes | No |
| Place travelled from | Place travelled to | Date left usual place of residence | Date returned to usual place of residence |
| *(Country/City/ Town)* | *(Country/City/ Town)* | | |
| *(Country/City/ Town)* | *(Country/City/ Town)* | | |

| Notifying health care provider's details | | | |
|---|---|---|---|
| First name | | Mobile number | |
| Surname | | Email address | |
| Notifier's signature | | SANC/HPCSA number | |

***Send to NMCsurveillanceReport@nicd.ac.za or fax to 086 639 1638 or NMC hotline 072 621 3805 and to the sub-district/district office***

[6] **COPD - Chronic obstructive pulmonary disease**