NOTIFICATION OF INFECTIOUS DISEASE OR FOOD POISONING

PLEASE USE BLOCK CAPITALS AND WHERE APPLICABLE FILL IN ONE CHARACTER PER BOX

SECTION 1 - PATIENT DETAILS

SURNAME:		**NHS No:**	
FORENAME:			
HOME ADDRESS/ CURRENT RESIDENCE:			
POSTCODE:	**TELEPHONE NO:**		
Date of Birth:	**Age:** **Sex:**	**Occupation:**	

ETHNICITY: Please tick as appropriate

White British		Black/Black British African		White & Black Caribbean		Asian/Asian British Indian		Other Black		Other	
White Irish		Black/Black British Caribbean		White & Black African		Asian/Asian British Pakistani		Other Asian		Not stated	
White other		Chinese		White & Asian		Asian/Asian British Bangladeshi		Other mixed			

SECTION 2 - DISEASE DETAILS

Date of Onset:	**Date of Diagnosis:**	**Date of Death:** (If applicable)

Notifiable Disease - Please tick appropriate box

Anthrax		Malaria				SARS	
Botulism		Measles				Scarlet fever	
Brucellosis		Meningococcal Septicaemia				Smallpox	
Cholera		Meningitis (specify below)				Tetanus	
Diphtheria		- Viral		Meningococcal		Tuberculosis	
Encephalitis (Acute)		- Haemophilus		Pneumococcal		Typhoid	
Hepatitis - Specify A, B, C, D or E		- Unspecified		Other Specified		Typhus	
- Unspecified		Mumps				Viral Haemorrhagic Fever	
Presumed Contracted Abroad	Yes / No	Paratyphoid				Whooping Cough	
HUS		Plague				Yellow Fever	
iGAS		Polio (Acute)				Other – Specify below	
Legionnaires' Disease		Rabies					
Leprosy		Rubella					

SECTION 2a - FOR GASTROINTESTINAL DISEASE/FOOD POISONING ONLY

Infectious Bloody Diarrhoea:	Shigella		E. Coli VTEC		Other		(Please tick as appropriate)	Yes	No	NK
Food Poisoning:	Campylobacter		Cryptosporidium		Giardia		**Presumed Contracted Abroad**			
	Salmonella		Other		Not Known		**Sample Taken**			

SYMPTOMS:	Vomiting		Diarrhoea		Jaundice		Fever		Other (please specify):		

CASE EMPLOYED IN/ATTENDS A HIGH RISK GROUP (PLEASE TICK IF APPLICABLE):

Food Handler		Nursery/Playgroup		Healthcare		Under Fives	

ANY OTHER MEMBER OF HOUSEHOLD EMPLOYED IN/ATTENDS A HIGH RISK GROUP (PLEASE TICK IF APPLICABLE):

Food Handler		Nursery/Playgroup		Healthcare		Under Fives	

SECTION 3 - FOREIGN TRAVEL

COUNTRY/ COUNTRIES VISITED:		**DATES OF TRAVEL:**	**From:**
			To:

SECTION 4 – GP (circle name) and PRACTICE DETAILS

	COMMENTS: (if relevant, please give any temporary or work/school address on the back of this form)
	Signature of Notifying Dr:
	Date of Notification:
Please Return To: or **Fax To:**	[redacted]

IF YOU NOTIFY US, YOU DO NOT NEED TO NOTIFY YOUR LOCAL AUTHORITY

SAMPLE ONLY