

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): (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 ____ / ____ / ____ (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"/> Meningococcal infection (invasive) <input type="checkbox"/> Middle East Respiratory Syndrome <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
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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: