



**HOSPITAL MELAKA**

# **PROSEDUR KUALITI**

**Notifikasi Kes Penyakit Berjangkit**

**No. Dokumen**

**PK - HM - KS - 03**

**No. Keluaran : 01**

**Disemak oleh**

**Tandatangan :**

**Nama : DR. NUR HAZIRAH BINTI ABD HALIM**

**Jawatan : KETUA UNIT KESIHATAN AWAM**

**Tarikh : 15.01.2018**

**Disokong oleh**

**Tandatangan :**

**Nama : DR. MOHD ROSLI BIN TOMPANG**

**Jawatan : TIMBALAN PENGARAH PERUBATAN III**

**Tarikh : 15.01.2018**

**Diluluskan oleh**

**Tandatangan :**

**Nama : DR. HATIJAH BINTI HJ. MOHD TAN**

**Jawatan : PENGARAH**

**Tarikh : 15.01.2018**



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**Tarikh: 15.01.2018**

**REKOD PINDAAN**

<b>Bil.</b>	<b>Nombor / Tajuk Dokumen</b>	<b>Keluaran</b>	<b>Keterangan</b>	<b>Mukasurat terlibat</b>	<b>Tarikh Pindaan</b>



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## **Notifikasi Kes Penyakit Berjangkit**

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### **1. OBJEKTIF**

Menguruskan pemantauan penyakit-berjangkit (*Surveillance System*) bagi memastikan kawalan dan pencegahan penyakit-berjangkit dapat dijalankan dengan efektif di semua peringkat.

Prosedur ini menyediakan garis panduan bagi memastikan sistem notifikasi penyakit-berjangkit yang efisien dari wad ke pejabat kesihatan daerah serta dapat mengesan awal kes wabak untuk tujuan tindak balas, penyiasatan dan pelaksanaan langkah-langkah kawalan yang berkesan.

### **2. SKOP**

1. Prosedur ini merangkumi mengumpul, merekod, melapor dan memantau maklumat kes penyakit-berjangkit di Hospital Melaka.
2. Prosedur ini digunapakai oleh warga kerja Hospital Melaka yang terlibat dalam merawat pesakit kes penyakit-berjangkit (Rujuk Akta Kawalan dan Pencegahan Penyakit–Berjangkit 1988)

### **3. RUJUKAN**

1. Akta Kawalan Dan Pencegahan Penyakit- Berjangkit 1988, Perintah Pencegahan dan Pengawalan Penyakit Berjangkit (Pindaan Jadual Pertama) 2016
2. Case Definitions For Infectious Diseases In Malaysia, 3<sup>rd</sup> Edition January 2017
3. Standard Operating Procedure For Potential Infectious Disease , 1<sup>st</sup> Edition 2004
4. Syndromic Notifications And Laboratory Investigation Manual 2008
5. Hand, Foot, Mouth Disease (HFMD) Guidelines 2010
6. Measles Prevention and Control in Malaysia , March 2012
7. Infectious Diseases Outbreak Rapid Response Manual , 1<sup>st</sup> edition, June 2003
8. Surat Pekeliling Ketua Pengarah Kesihatan Malaysia Bil. 1/2006 : Keperluan Melaporkan Kejadian Wabak Penyakit- Berjangkit
9. Surat Pekeliling Ketua Pengarah Kesihatan Malaysia Bil. 1 Tahun 2015: Pemberitahuan Notifikasi Secara Pentadbiran Bagi Melioidosis
10. Surat Kementerian Kesihatan Malaysia bertarikh 6 September 2012 : Pemberitahuan Keperluan Bagi Membuat Notifikasi Penyakit Brucellosis Secara Pentadbiran
11. Surat Pekeliling Ketua Pengarah Kesihatan Malaysia Bil. 24/2010 : Pengukuhan Program Eliminasi Measles Kebangsaan (Measles Elimination Program-MEP)

12. Guidelines For The Diagnosis, Management, Prevention and Control of Brucellosis in Malaysia, 1<sup>st</sup> Edition, 2012

13. Interim Guideline Prevention & Control For Human Rabies in Malaysia, 1 Oktober 2018

#### **4. TERMINOLOGI**

<b>HM</b>	Hospital Melaka
<b>MO</b>	Medical Officer
<b>TPP(III)</b>	Timbalan Pengarah Perubatan (III)
<b>PPKPK</b>	Penolong Pegawai Kesihatan Persekitaran Kanan
<b>PPKP</b>	Penolong Pegawai Kesihatan Persekitaran
<b>PKA</b>	Pembantu Kesihatan Awam
<b>PPK</b>	Pembantu Perawatan Kesihatan
<b>PA</b>	Pembantu Awam
<b>JKNM</b>	Jabatan Kesihatan Negeri Melaka
<b>PKD</b>	Pejabat Kesihatan Daerah
<b>PKD MT</b>	Pejabat Kesihatan Daerah Melaka Tengah
<b>PKD AG</b>	Pejabat Kesihatan Daerah Alor Gajah
<b>UKA</b>	Unit Kesihatan Awam
<b>HO</b>	House Officer



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### 5. TANGGUNGJAWAB DAN TINDAKAN

TANGGUNGJAWAB	TINDAKAN
	<b>5.1. NOTIFIKASI KES PENYAKIT-BERJANGKIT</b>
HO/MO (Wad/ED/Klinik Pakar)	5.1.1. Mengisi borang notifikasi penyakit-berjangkit (rujuk senarai borang dalam lampiran) di fasiliti masing-masing.
MO/Penyelia/Jururawat	5.1.2. Memberi maklumat kes penyakit-berjangkit yang perlu dinotifikasi dalam tempoh masa 24 jam (sila rujuk 6.1) secara panggilan telefon ke PKD MT.
PPK	5.1.3. Menghantar salinan asal yang lengkap ke pejabat UKA melalui serahan secara manual. Satu salinan (merah) disimpan dalam rekod pesakit.
PPKPK / PPKP / PKA	5.1.4. Menerima salinan asal dari semua fasiliti Hospital Melaka.
PPKPK / PPKP / PKA	5.1.5. Memastikan kelancaran sistem E-notifikasi melalui laman web <a href="http://enotifikasi.moh.gov.my">http://enotifikasi.moh.gov.my</a>
PPKPK / PPKP / PKA	5.1.6. Meneliti semua maklumat di dalam setiap borang notifikasi. Sekiranya maklumat yang diberikan tidak lengkap, borang notifikasi tersebut akan dikembalikan serta-merta kepada <i>notifier</i> untuk pembetulan.
PPKPK / PPKP / PKA	5.1.7. Memastikan kes yang dinotifikasi disemak melalui sistem E-Notifikasi bagi mengelakkan kes duplikasi.
PPKPK / PPKP / PKA	5.1.8. Memasukkan data ke dalam E-Notis dan memberi maklumat bagi kes-kes yang perlu dinotifikasi dalam tempoh 24 jam (rujuk 6.1) melalui faksimili ke PKD MT.
PPKPK / PPKP / PKA	5.1.9. Menyediakan laporan mingguan pencapaian notifikasi penyakit-berjangkit HM.
MO UKA	5.1.10. Menyemak laporan pencapaian notifikasi penyakit-berjangkit HM.
TPP (III)	5.1.11. Mengesahkan laporan pencapaian notifikasi penyakit-berjangkit HM.
PPKPK / PPKP / PKA	5.1.12. Menghantar laporan kepada Pengarah HM.
PPKPK / PPKP / PKA	5.1.13. Menghantar salinan asal borang notifikasi ke PKD MT/PKD Jasin/ PKD AG dan membuat salinan baru untuk disimpan di dalam fail.



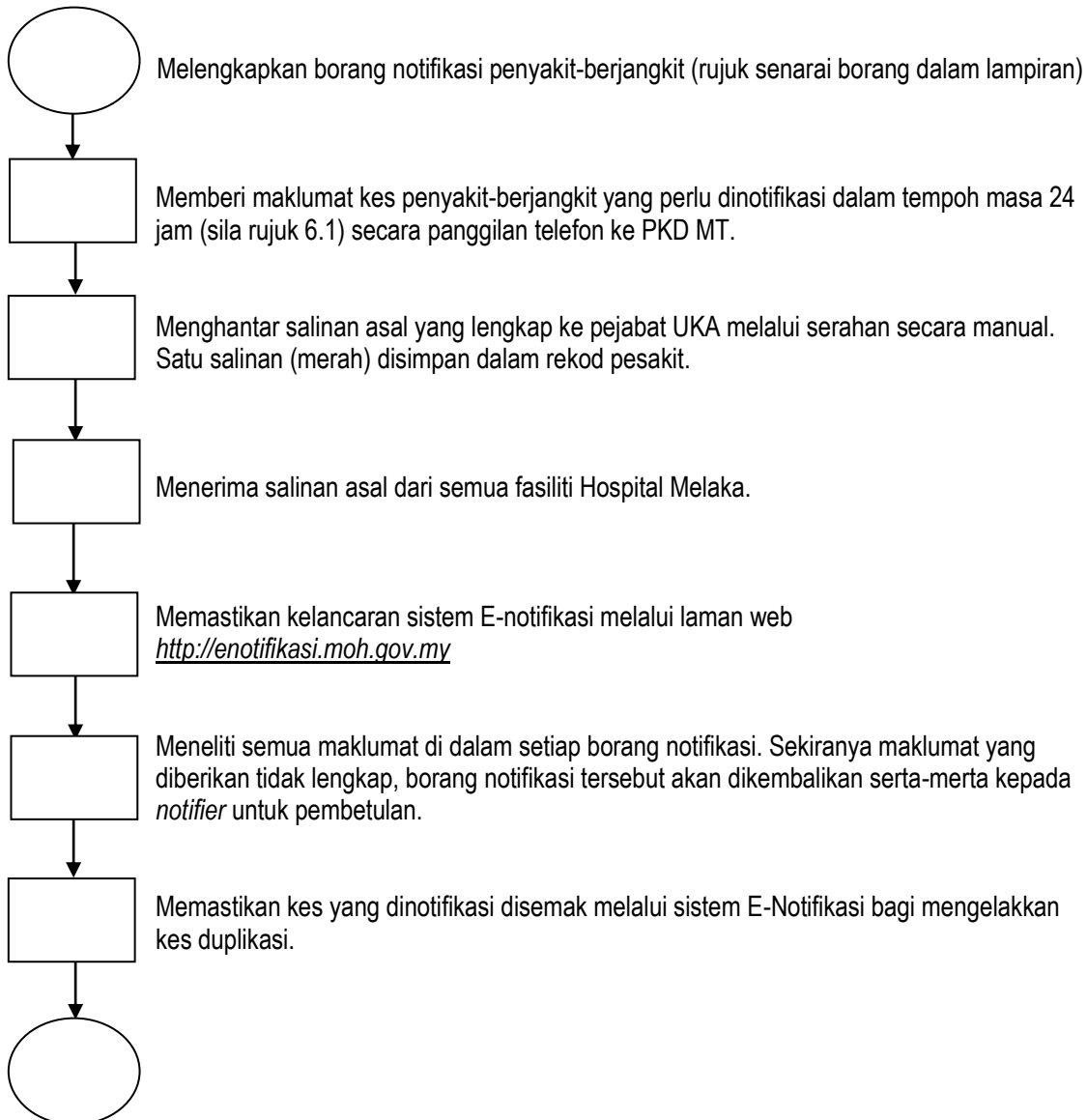
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### 6. CARTA ALIRAN



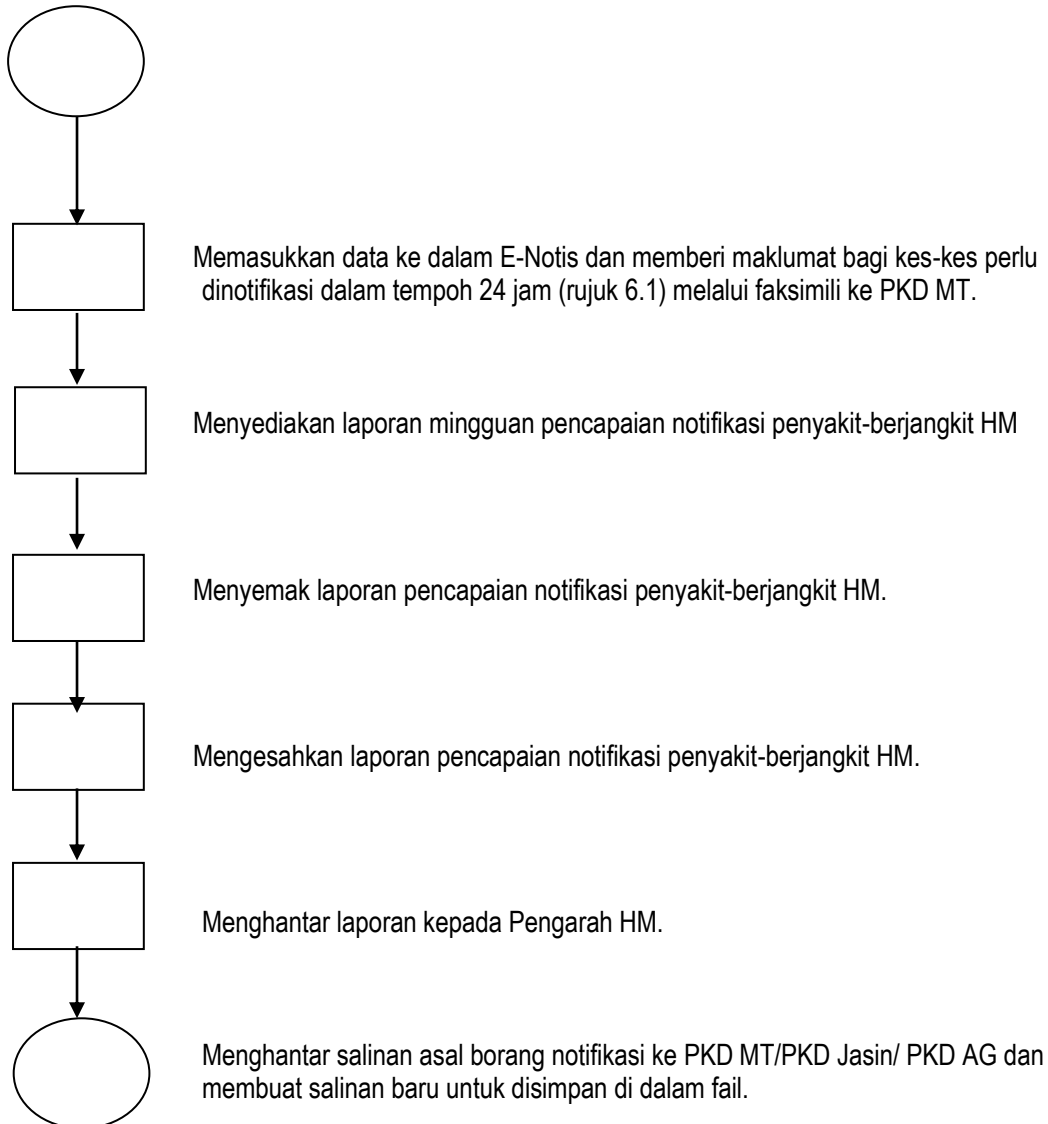



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 <b>HOSPITAL MELAKA</b>	<b>PROSEDUR KUALITI</b> <b>Notifikasi Kes Penyakit Berjangkit</b>	<b>No. Pindaan: 00</b> <b>Tarikh: 15.01.2018</b>
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## 7. REKOD KUALITI

BIL.	JENIS REKOD	LOKASI	TEMPOH SIMPANAN
1.	Salinan borang notifikasi penyakit-berjangkit	Unit Kesihatan Awam	4 Tahun

## LAMPIRAN

- 1 Akta Kawalan Dan Pencegahan Penyakit- Berjangkit 1988, Perintah Pencegahan dan Pengawalan Penyakit Berjangkit (Pindaan Jadual Pertama) 2016
- 2 Borang Notifikasi Penyakit- Berjangkit (Seksyen 10, Akta Pencegahan Dan Pengawalan Penyakit Berjangkit 1988) , Borang: Health 1 Rev.2005
- 3 Notification Form For MERS-CoV Case, Annex 4, Guidelines of MERS Management In Malaysia
- 4 Notification Form For Severe Acute Respiratory Syndrome (SARS), Appendix 4, KKM/BKP/SARS/2003/Pind.3
- 5 Notification Form For Influenza A(H1N1) Case , Annex 2, KKM/BKP/SF2009/1
- 6 Melioidosis Investigation Form, Appendix 8, Guidelines of Clinical And Public Health Manangement Of Melioidosis
- 7 Acute Flaccid Paralysis Case Investigation Form, Annex 1, POLIOIx/1-2008
- 8 Syndromic Notification Form, Appendix 3, KKM- syndssurv/2003.2
- 9 AIDS Notification Form, PER (23) dalam KKM-171 (193/6), Borang HIV/AIDS-97
- 10 Dog Bite Surveillance, Annex 1a, Interim Guideline For Human Rabies Prevention & Control In Malaysia
- 11 Borang TBIS 10A-1, Sistem Maklumat Tibi, KKM
- 12 Notification Form For Zika Virus, Zika1 /case/2016

## 8. PENGURUSAN RISIKO

Rujuk Fail Pengurusan Risiko.

## 9. KLAUSA BERKAITAN

- 4.0 Konteks organisasi
- 5.0 Kepimpinan
- 6.1 Tindakan menyatakan risiko & peluang
- 7.4 Komunikasi
- 7.5 Maklumat didokumentasikan
- 9.0 Penilaian prestasi



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1. Akta Kawalan Dan Pencegahan Penyakit- Berjangkit 1988, Perintah Pencegahan dan Pengawalan Penyakit Berjangkit (Pindaan Jadual Pertama) 2016

P.U. (A) 298

### AKTA PENCEGAHAN DAN PENGAWALAN PENYAKIT BERJANGKIT 1988

#### PERINTAH PENCEGAHAN DAN PENGAWALAN PENYAKIT BERJANGKIT (PINDAAN JADUAL PERTAMA) 2016

PADA menjalankan kuasa yang diberikan oleh seksyen 30 Akta Pencegahan dan Pengawalan Penyakit Berjangkit 1988 [Akta 342], Menteri membuat perintah yang berikut:

#### Nama dan permulaan kuat kuasa

1. (1) Perintah ini bolehlah dinamakan **Perintah Pencegahan dan Pengawalan Penyakit Berjangkit (Pindaan Jadual Pertama) 2016**.

(2) Perintah ini mula berkuat kuasa pada 1 Disember 2016.

#### Pindaan Jadual Pertama

2. Jadual Pertama kepada Akta Pencegahan dan Pengawalan Penyakit Berjangkit 1988 dipinda dengan menggantikan Bahagian I dengan Bahagian yang berikut:

#### "BAHAGIAN I

1. *Avian Influenza*
2. Batuk Kokol
3. Campak
4. *Chancroid*
5. Demam denggi dan demam denggi berdarah
6. Demam kuning
7. Difteria
8. Disenteri (Semua jenis)
9. Ebola
10. Jangkitan Gonococcal (Semua jenis)



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11. Jangkitan virus Zika
12. Leptospirosis
13. Keracunan makanan
14. Kolera
15. Kusta
16. Malaria
17. *Middle East Respiratory Syndrome Coronavirus* (MERS-CoV)
18. Penyakit tangan, kaki dan mulut (HFMD)
19. *Plague*
20. Poliomielititis (Akut)
21. *Rabies*
22. *Relapsing fever*
23. Sifilis (Semua jenis)
24. Tetanus (Semua jenis)
25. Tifoid dan *paratyphoid*
26. Tifus dan ricketsioses lain
27. Tuberkulosis (Semua jenis)
28. Viral ensefalitis
29. Viral hepatitis
30. Apa-apa jangkitan microbial lain yang mengancam nyawa\*.

Dibuat 28 November 2016  
[KKM(KA)196(55/4)]Id1; PN(PU2)470/III]

DATUK SERI DR. S. SUBRAMANIAM  
*Menteri Kesihatan*



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2. Borang Notifikasi Penyakit- Berjangkit (Seksyen 10, Akta Pencegahan Dan Pengawalan Penyakit Berjangkit 1988) , Borang: Health 1 Rev.2005

### NOTIFIKASI PENYAKIT BERJANGKIT YANG PERLU DILAPORKAN

(Seksyen 10, Akta Pencegahan Dan Pengawalan Penyakit Berjangkit 1988)

A. MAKLUMAT PESAKIT		
1. Nama Penuh (HURUF BESAR): <input type="text"/>		
Nama Pengiring (Ibu/Bapa/Penjaga): <input type="text"/> <i>(Jika belum mempunyai Kad Pengenalan diri)</i>		
2. No. Kad Pengenalan Diri / Dokumen Perjalanan <input type="text"/> <input type="checkbox"/> Sendiri <input type="checkbox"/> Pengiring <i>(Untuk Bukan Warganegara)</i>		
No. Daftar Hospital / Klinik <input type="text"/> Nama Wad: <input type="text"/> Tarikh Masuk Wad: <input type="text"/> / <input type="text"/> / <input type="text"/>		
3. Kewarganegaraan: Warganegara: <input type="checkbox"/> Ya    Keturunan: <input type="text"/> Sukuketurunan: <input type="text"/> <i>(Bagi O/Asli, Pribumi Sabah/Sarawak)</i> <input type="checkbox"/> Tidak    Negara Asal: <input type="text"/> Status Kedatangan: <input type="checkbox"/> Izin <input type="checkbox"/> Tanpa Izin <input type="checkbox"/> Penduduk Tetap		4. Jantina: <input type="checkbox"/> Lelaki <input type="checkbox"/> Perempuan 5. Tarikh Lahir: <input type="text"/> / <input type="text"/> / <input type="text"/> 6. Umur: <input type="text"/> <input type="checkbox"/> Tahun <input type="text"/> Bulan <input type="text"/> Hari 7. Pekerjaan: <input type="text"/> <i>(Jika tidak bekerja, nyatakan status diri)</i>
8. No. Telefon: <input type="checkbox"/> Rumah <input type="checkbox"/> Tel. Bimbit <input type="checkbox"/> Pejabat <input type="text"/> - <input type="text"/> <i>(Untuk dihubungi)</i>		
9. Alamat Kediaman <input type="text"/>		10. Alamat Tempat Kerja / Belajar: <input type="text"/>
B. DIAGNOSIS PENYAKIT		
<input type="checkbox"/> 1. Acquired Immune Deficiency Syndrome (AIDS)	<input type="checkbox"/> 16. Kusta ( <i>Multibacillary</i> )	<input type="checkbox"/> 31. Tifoid - ( <i>Smith</i> )
<input type="checkbox"/> 2. Batu Kukul	<input type="checkbox"/> 17. Malaria - ( <i>Falciplum</i> )	<input type="checkbox"/> 32. Tifoid - ( <i>Paratyphoid</i> )
<input type="checkbox"/> 3. Campak	<input type="checkbox"/> 18. Malaria - ( <i>Malariae</i> )	<input type="checkbox"/> 33. Tifoid - ( <i>Salmonella typhi</i> )
<input type="checkbox"/> 4. Chancroid	<input type="checkbox"/> 19. Malaria - ( <i>Vivax</i> )	<input type="checkbox"/> 34. Tuberkulosis - (Pul. - S/Kahak Negatif)
<input type="checkbox"/> 5. Demam Denggi	<input type="checkbox"/> 20. Malaria - ( <i>Lain-lain</i> )	<input type="checkbox"/> 35. Tuberkulosis - (Pul. - S/Kahak Positif)
<input type="checkbox"/> 6. Demam Denggi Berdarah	<input type="checkbox"/> 21. Penyakit Tangan, Kaki dan Mulut	<input type="checkbox"/> 36. Tuberkulosis - ( <i>Lain-lain Pulmonari</i> )
<input type="checkbox"/> 7. Demam Kuning	<input type="checkbox"/> 22. Plague - ( <i>Bubonic</i> )	<input type="checkbox"/> 37. Viral Ensefalitis - ( <i>Japanese</i> )
<input type="checkbox"/> 8. Difteria	<input type="checkbox"/> 23. Plague - ( <i>Pneumonic</i> )	<input type="checkbox"/> 38. Viral Ensefalitis - ( <i>Nipah</i> )
<input type="checkbox"/> 9. Disenteri ( <i>Semua Jenis</i> )	<input type="checkbox"/> 24. Poliomiellitis (Akut)	<input type="checkbox"/> 39. Viral Ensefalitis - ( <i>Lain-lain</i> )
<input type="checkbox"/> 10. Ebola	<input type="checkbox"/> 25. Rabies	<input type="checkbox"/> 40. Viral Hepatitis A (Akut)
<input type="checkbox"/> 11. Gonorrhoea	<input type="checkbox"/> 26. Relapsing Fever	<input type="checkbox"/> 41. Viral Hepatitis B (Akut)
<input type="checkbox"/> 12. Human Immunodeficiency Virus Infection (HIV)	<input type="checkbox"/> 27. Sifilis - ( <i>Acquired</i> )	<input type="checkbox"/> 42. Viral Hepatitis C (Akut)
<input type="checkbox"/> 13. Keracunan Makanan	<input type="checkbox"/> 28. Sifilis - ( <i>Congenital</i> )	<input type="checkbox"/> 43. Viral Hepatitis ( <i>Lain-lain</i> ) - (Akut)
<input type="checkbox"/> 14. Kolera	<input type="checkbox"/> 29. Tetanus ( <i>Neonatorum</i> )	
<input type="checkbox"/> 15. Kusta ( <i>Multibacillary</i> )	<input type="checkbox"/> 30. Tetanus ( <i>Lain-lain</i> )	
Selain dari notifikasi bertulis, penyakit berikut perlu dinotifikasi melalui telefon dalam tempoh 24 jam iaitu:- Poliomiellitis Akut, Kolera, Denggi, Diphtheria, Keracunan Makanan, Plague, Rabies dan Demam Kuning.		
11. Pengesanan Kes: <input type="checkbox"/> Kes <input type="checkbox"/> Kontak <input type="checkbox"/> FOMEMA * <input type="checkbox"/> Ujian Saringan	12. Status Pesakit: <input type="checkbox"/> Hidup <input type="checkbox"/> Mati <input type="text"/> - <input type="text"/> - <input type="text"/>	13. Tarikh Onset: <input type="text"/> - <input type="text"/> - <input type="text"/>
14. Ujian Makmal: Nama Ujian: (i) _____ (ii) _____ (iii) _____ Tarikh Sampel Diambil: <input type="text"/> - <input type="text"/> - <input type="text"/>	15. Keputusan Ujian Makmal: <input type="checkbox"/> Positif ( _____ ) <input type="checkbox"/> Negatif <input type="checkbox"/> Belum Siap	16. Status Diagnosis: <input type="checkbox"/> Sementara ( <i>Provisional/Suspected</i> ) <input type="checkbox"/> Disahkan ( <i>Confirmed</i> ) Tarikh Diagnosis <input type="text"/> - <input type="text"/> - <input type="text"/>
17. Maklumat Klinikal Yang Relevan: <input type="text"/>	18. Komen: <input type="text"/>	
C. MAKLUMAT PEMBERITAHU		
19. Nama Pengamal Perubatan: <input type="text"/>		
20. Nama Hospital / Klinik dan Alamat: <input type="text"/>		
21. Tarikh Notifikasi: <input type="text"/> - <input type="text"/> - <input type="text"/>		
Tandatangan Pencamal Perubatan		

\* Agensi Pemantauan Pemeriksaan Kesihatan Pekerja Asing (FOMEMA)



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### 3. Notification Form For MERS-CoV Case, Annex 4, Guidelines of MERS Management In Malaysia

' Annex 3 '



NOTIFICATION FORM  
FOR MERS CASE  
Disease Control Division  
Ministry Of Health Malaysia

1. Reporting Centre		Name of Hospital / Clinic:		State:	
Phone:		Fax:		E-mail:	
2. Information of Patient		Name:		Age: ___yr ___mth	
				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			Phone (Home):		RN No:
Nationality:		Ethnicity: <input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other, specify:		IC No:	
<input type="checkbox"/> Malaysian <input type="checkbox"/> Non Malaysian		Country of Origin:		Passport No:	
Occupation		: <input type="checkbox"/> Health Care Worker <input type="checkbox"/> Others, please state:		Date of symptom onset [dd/mm/yy]:	
3. Signs and Symptoms		<input type="checkbox"/> Fever <input type="checkbox"/> Cough <input type="checkbox"/> Sorethroat <input type="checkbox"/> Myalgia <input type="checkbox"/> Headache		<input type="checkbox"/> Shortness of breath/difficulty breathing	
		Temperature on admission: ____°C		<input type="checkbox"/> Other symptoms, specify:	
4. Chest X-Ray finding		Evidence of lung infiltrates consistent with pneumonia		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	
5. Is there any alternative diagnosis that can fully explain patient's illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Clinical status at time of report		Was patient hospitalised?		Ward:	
		<input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> Brought In Dead (BID) Date: _____		<input type="checkbox"/> Isolation ward <input type="checkbox"/> General ward <input type="checkbox"/> ICU	
				Progress: <input type="checkbox"/> On treatment, specify: _____ <input type="checkbox"/> Died Date: _____	
If patient died: Was post mortem performed?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending			
7. Exposure History		Did patient had history of close contact with a confirmed MERS-CoV patient?		Name: Address:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Travel History		Has the patient travelled to areas reporting confirmed cases of MERS-CoV prior to onset of symptoms			
		<input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please specify:</i>			
		Country/State/province visited		Duration of stay	
				From [dd/mm/yr] To [dd/mm/yr]	
		Name of Airline & Flight No./Cruise/Other mode of transportation			
1.					
2.					
3.					
Date of return to Malaysia:		Entry point:			
9. Similar illness		Anybody in the neighbourhood having similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Diagnostic Evaluation		Date taken	Date send to lab	Name of laboratory	Result
Virology					
11. Working diagnosis: (please state)					
12. Reporting Officer:		Date:		Signature:	
Designation:				H/phone No:	
For District Health Office use only					
13. Contact Tracing		Has contact tracing been done? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of contact with similar illness:	
		Date of contact tracing done:		Number of contact isolated:	
		Number of contacts examined:		Number of contact referred to hospital:	
14. Active case finding		Has active case finding been initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No		No. of cases referred to hospital:	
		Number of people with similar illness:		Number of cases isolated:	
15. Investigating Officer:		Date:		Signature:	
Designation:				H/Phone No:	
For Disease Control Division use only					
COMMENTS:					



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### 4. Notification Form For Severe Acute Respiratory Syndrome (SARS), Appendix 4, KKM/BKP/SARS/2003/Pind.3

Appendix 4

KKM/BKP/SARS/2003/Pind.3

### NOTIFICATION FORM FOR SEVERE ACUTE RESPIRATORY SYNDROME (SARS)

For Disease Control  
Division use only  
ID No:

Disease Control Division

Ministry Of Health Malaysia

Note: Please fax this form within 24 hours to District Health Office

1. Reporting Centre		Name of Hospital:		State	
Phone:		Fax:		E-mail:	
2. Information of Patient		Name:		Age	Sex ( ) Male ( ) Female
Address:		Phone(Home):		RN No:	
Nationality		Ethnicity: M / C / I / Other Please specify:		H/Phone:	
( ) Malaysian		Country of Origin		IC No:	
( ) Non Malaysian		Passport No:		Date of symptom onset [dd/mm/yr]	
Healthcare worker ( ) Yes. Category: _____ Place: _____ (Ward/clinic/etc)		( ) No			
3. Signs and Symptoms		( ) Fever ( ) Cough			
		Temperature: _____ Place taken: oral / axilla / other (Specify)			
4. Chest X-ray finding		Evidence of lung infiltrates consistent with pneumonia or RDS ( ) Yes ( ) No			
5. Is there any alternative diagnosis that can fully explain patient's illness?		( ) Yes ( ) No			
6. Clinical status at time of report		Was patient hospitalized? ( ) Yes, Date: _____ ( ) Brought In Dead (BID) Date: _____		Ward: ( ) Isolation ward ( ) General ward ( ) ICU Ward ( ) On treatment ( ) Died Date: _____	
If patient died: Was an autopsy performed? ( ) Yes ( ) No ( ) Pending		Was pathology consistent with Respiratory Distress Syndrome? ( ) Yes ( ) No			
7. Exposure History		Indicate if the patient was in *close contact with SARS case: ( ) Yes ( ) No If yes, please state the name and address of the person Name: _____ Address: _____			
8. Travel History		Has the patient travelled to any of the following destinations within 10 days prior to onset of symptoms ( ) Yes, if yes please state the country ( ) No			
	Country/State/ province visited	Duration of stay From [dd/mm/yr] To [dd/mm/yr]		Name of Airline & Flight No/ Cruise/ Other mode of transportation	
1					
2					
3					
Date of return to Malaysia:		Entry point:			
9. Diagnostic Evaluation		Date taken	Date send to IMR	Result	
Virology					
10. Working diagnosis (Please state)					
11. Contact tracing ( to be filled by District Health Office)		Has contact tracing been initiated? ( ) Yes ( ) No Number of contacts: _____ No. on home quarantine: _____ No. on active surveillance: _____			
12. Reporting Officer:		Signature:			
Designation:		Date:	H/Phone No:		
For Disease Control Division use only					
Review by : Date:		Comments:			
SARS					
Not SARS					

\*Close contact: having cared for, lived with, or had direct contact with respiratory secretions or body fluids of a suspect or probable case of SARS



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### 5. Notification Form For Influenza A(H1N1) Case , Annex 2, KKM/BKP/SF2009/1

Annex 2

NOTIFICATION FORM  
FOR INFLUENZA A(H1N1) CASE  
Disease Control Division  
Ministry Of Health Malaysia

KKM/BKP/SF/2009/1



For Disease Control  
Division use only  
ID No:

1. Reporting Centre		Name of Hospital / Clinic:		State:	
Phone:		Fax:			
2. Information of Patient		Name:		Age:	
				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:			Phone (Home):		RN No
Nationality:		Ethnicity: <input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other, specify:			IC No
<input type="checkbox"/> Malaysian <input type="checkbox"/> Non Malaysian		Country of Origin:		Passport No:	
Occupation : <input type="checkbox"/> Health Care worker <input type="checkbox"/> Plg Farmer <input type="checkbox"/> Others, please state:				Date of symptom onset (dd/mm/yy):	
3. Signs and Symptoms		<input type="checkbox"/> Fever <input type="checkbox"/> Sorethroat		<input type="checkbox"/> Cough <input type="checkbox"/> Myalgia <input type="checkbox"/> Headache	
		Temperature on admission: 38C		<input type="checkbox"/> Shortness of breath/difficulty in breathing	
		<input type="checkbox"/> Other symptoms, specify :			
4. Chest X-Ray finding		Evidence of lung infiltrates consistent with pneumonia		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not done	
5. Is there any alternative diagnosis that can fully explain patient's illness?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Clinical status at time of report		Was patient hospitalised? Yes <input type="checkbox"/> <input type="checkbox"/> Brought In Dead (BID) Date:		Ward: <input type="checkbox"/> Isolation ward <input type="checkbox"/> General ward <input type="checkbox"/> ICU/CCU	
				Progress: <input type="checkbox"/> On treatment: <input type="checkbox"/> Died Date:	
If patient died: Was post mortem performed?				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
7. Exposure History		Did patient had history of close contact with Influenza A(H1N1) patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please state the name and address Name: Address:	
8. Travel History		Has the patient travelled to any of the following destinations after 17 April 2009 prior to onset of symptoms <input type="checkbox"/> Mexico <input type="checkbox"/> Texas <input type="checkbox"/> California <input type="checkbox"/> New York <input type="checkbox"/> Kansas <input type="checkbox"/> Ohio <input type="checkbox"/> Other areas reporting confirmed cases of Influenza A(H1N1), please specify:			
		Country/State/province visited		Duration of stay	
				From[dd/mm/yr] To[dd/mm/yr]	
				Name of Airline & Flight No/Cruise/Other mode of transportation	
		Date of return to Malaysia:		Entry point:	
9. Similar illness		Anybody in the neighbourhood having similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Diagnostic Evaluation		Date taken		Date send to lab	
				Name of laboratory	
				Result	
		Throat Swab			
11. Working diagnosis: (please state)		ILI TRO H1N1			
12. Reporting Officer:		Signature:			
Designation: Pegawai Perubatan		Date:		H/phone	
For District Health Office use only					
13. Contact Tracing		Has contact tracing been done? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of contact tracing done: Number of contacts examined:		Number of contact with similar illness: Number of contact quarantined: Number of contact referred to hospital:	
14. Active case finding		Has active case finding been initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of people with similar illness:		No. of cases referred to hospital: Number of cases quarantined:	
15. Investigating Officer:		Signature:			
Designation:		Date:		H/Phone No:	
For Disease Control Division use only					
COMMENTS:					

NOTE: Please fax this form within 24 hours to District Health Office



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

6. Melioidosis Investigation Form, Appendix 8, Guidelines of Clinical And Public Health Management Of Melioidosis

**MELIOIDOSIS INVESTIGATION FORM**

**SECTION A: TO BE COMPLETED BY TREATING HOSPITAL**

**PERSONAL INFORMATION**

1.00 Date of registration  DD  MM      YYYY

2.00 RN

3.00 Name

4.00 New IC

5.00 Other IC

6.00 Date of birth  DD  MM      YYYY

7.00 Age  years/months/days\*

8.00 Gender  Male  Female

9.00 Race  Malay  Chinese  Indian  
 Orang Asli  Other

10.00 Nationality  Malaysian  Non-Malaysian  
Specify:

11.00 Occupation *Current occupation. Choose only ONE answer.*

**Managerial and professional specialty occupations:**

[1] Executive, administrative, and managerial occupations

[2] Professional specialty occupations

**Technical, sales, and administrative support occupations:**

[3] Technicians and related support occupations

[4] Sales occupations

[5] Administrative support occupations, including clerical

**Service occupations:**

[6] Private household occupations

[7] Protective service occupations

[8] Service occupations, except protective and household

[9] Farming, forestry, and fishing occupations

[10] Precision production, craft, and repair occupations

**Operators, fabricators, and laborers:**

[11] Machine operators, assemblers, and inspectors

[12] Transportation and material moving occupations

[13] Handlers, equipment cleaners, helpers, and laborers

**Others**

[14] Housewife

[15] Student

[16] Not relevant (children)

[17] Unemployed



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### MELIJDOSIS INVESTIGATION FORM

Address

12.01

12.02

12.03 Postcode

12.04 City

12.05 State

13.00 Tel (H)

14.00 Tel (O)

15.00 Tel (HIP)

#### PAST HISTORY

16.00 Previous meliJDosis infection  Yes  No (If No, go to Question 23)

17.00 When was the previous infection?  years/months/weeks/days\* ago

18.00 Organ involved

- 18.01 Unknown  Yes  No
- 18.02 Pulmonary  Yes  No
- 18.03 Liver  Yes  No
- 18.04 Spleen  Yes  No
- 18.05 Skin/Subcutaneous tissue  Yes  No
- 18.06 Musculoskeletal  Yes  No
- 18.07 Others  Yes  No

If others, please specify

19.00 How the diagnosis was made

- 19.01 Culture  Yes  No
- 19.02 Serology  Yes  No
- 19.03 Clinical  Yes  No
- 19.04 Others  Yes  No

If others, please specify



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### MELIOIDOSIS INVESTIGATION FORM

Treatment History

			Dose	Duration
20.00	<input checked="" type="checkbox"/>	Intensive Phase		
20.01	<input type="checkbox"/>	Ceftazidime		
20.02	<input type="checkbox"/>	Amoxicillin-clavulanic		
20.03	<input type="checkbox"/>	Cefoperazone-sulbactam		
20.04	<input type="checkbox"/>	Trimethoprim-sulfamethoxazole		
20.05	<input type="checkbox"/>	Tetracycline		
20.06	<input type="checkbox"/>	Imipenam		
20.07	<input type="checkbox"/>	Meropenam		
20.08	<input type="checkbox"/>	Ciprofloxacin		
20.09	<input type="checkbox"/>	Others (Specify: )		
20.10	<input type="checkbox"/>	Others (Specify: )		
20.11	<input type="checkbox"/>	Others (Specify: )		
21.00	<input checked="" type="checkbox"/>	Maintenance Phase	Dose	Duration
21.01	<input type="checkbox"/>	Amoxicillin-clavulanic		
21.02	<input type="checkbox"/>	Chloramphenicol		
21.03	<input type="checkbox"/>	Trimethoprim-sulfamethoxazole		
21.04	<input type="checkbox"/>	Tetracycline		
21.05	<input type="checkbox"/>	Ciprofloxacin		
21.06	<input type="checkbox"/>	Others (Specify: )		
21.07	<input type="checkbox"/>	Others (Specify: )		
21.08	<input type="checkbox"/>	Others (Specify: )		
22.00	<input type="checkbox"/>	No antibiotic given		

23.00 Underlying illnesses

23.01	Diabetes mellitus	[1] <input type="checkbox"/> Yes	[2] <input type="checkbox"/> No
23.02	Chronic renal failure	[1] <input type="checkbox"/> Yes	[2] <input type="checkbox"/> No
23.03	Alcohol abuse	[1] <input type="checkbox"/> Yes	[2] <input type="checkbox"/> No
23.04	Chronic lung disease	[1] <input type="checkbox"/> Yes	[2] <input type="checkbox"/> No
23.05	HIV/AIDS	[1] <input type="checkbox"/> Yes	[2] <input type="checkbox"/> No
23.06	Other immunocompromised state (e.g. Steroid)	[1] <input type="checkbox"/> Yes	[2] <input type="checkbox"/> No
23.07	Others	[1] <input type="checkbox"/> Yes	[2] <input type="checkbox"/> No

if others, please specify

---



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### MELIOIDOSIS INVESTIGATION FORM

24.00 Date of admission:  DD  MM  YYYY

25.00 Clinical presentation

- 25.01 Fever: [1]  Yes [2]  No
- 25.02 Duration:  months/weeks/days\*
- 25.03 Cough: [1]  Yes [2]  No
- 25.04 Duration:  months/weeks/days\*
- 25.05 Sputum: [1]  Yes [2]  No
- 25.06 Sputum colour: [1]  White [2]  Yellow  
[3]  Green [4]  Others (Specify: )
- 25.07 Hemoptysis: [1]  Yes [2]  No
- 25.08 Abdominal pain: [1]  Yes [2]  No
- 25.09 Dysuria: [1]  Yes [2]  No
- 25.10 Headache: [1]  Yes [2]  No
- 25.11 Others: [1]  Yes [2]  No
- Specify

26.00 Physical findings

- 26.01 Blood pressure:  /  SBP DBP
- 26.02 Pulse rate:  /min
- 26.03 Respiratory rate:  /min
- 26.04 Jaundice: [1]  Yes [2]  No
- 26.05 Joint swelling: [1]  Yes [2]  No  
If YES, how many joints involved?
- 26.06 Ulcer: [1]  Yes [2]  No Specify:
- 26.07 Cut/abrasion: [1]  Yes [2]  No Specify:
- 26.08 Hepatomegaly: [1]  Yes [2]  No
- 26.09 Splenomegaly: [1]  Yes [2]  No
- 26.10 Pleural effusion: [1]  Yes [2]  No
- 26.11 Others: [1]  Yes [2]  No
- Specify

27.00 Final clinical diagnosis

- 27.01 Pneumonia: [1]  Yes [2]  No
- 27.02 Soft tissue abscess: [1]  Yes [2]  No
- 27.03 Septic arthritis: [1]  Yes [2]  No
- 27.04 Osteomyelitis: [1]  Yes [2]  No
- 27.05 Prostatic abscess: [1]  Yes [2]  No
- 27.06 Liver abscess: [1]  Yes [2]  No
- 27.07 Splenic abscess: [1]  Yes [2]  No
- 27.08 Meningoencephalitis: [1]  Yes [2]  No
- 27.09 Brain abscess: [1]  Yes [2]  No
- 27.10 Pyelonephritis/UTI/Perinephric Abscess: [1]  Yes [2]  No
- 27.11 Others: [1]  Yes [2]  No
- Specify



MELIOIDOSIS INVESTIGATION FORM

INVESTIGATION

28.00 Investigation Findings

28.01 Hb   g/dL

28.02 WBC   x 1000/mL

28.03 Platelet   x 1000/mL

28.04 PT Patient   Control

28.05 PTT Patient   Control

28.06 INR

28.07 RBS   mmol/L

UFEME

28.08 WBC (1)  1+ (2)  2+ (3)  3+ (4)  4+

28.09 RBC (1)  1+ (2)  2+ (3)  3+ (4)  4+

28.10 Protein (1)  1+ (2)  2+ (3)  3+ (4)  4+

28.11 Urea   mmol/L

28.12 Creatinine   umol/L

Bilirubin

28.13 Conjugated     umol/L

28.14 Unconjugated     umol/L

28.15 Albumin     g/L

28.16 Globulin     g/L

28.17 AST     U/L

28.18 ALT     U/L

28.19 ALP     U/L

28.20 CXR

USG Abdomen

(Looking for abscess)

28.21 Liver abscess (1)  Single (2)  Multiple (3)  Normal

28.22 Splenic abscess (1)  Single (2)  Multiple (3)  Normal

28.23 Kidney abscess (1)  Single (2)  Multiple (3)  Normal

28.24 Prostate abscess (1)  Single (2)  Multiple (3)  Normal

28.50 Other finding: \_\_\_\_\_

28.25 CT Scan



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00

Tarikh: 15.01.2018

### MELIOIDOSIS INVESTIGATION FORM

29.00	Culture	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
29.01	Blood	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
29.02	Tissue	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
29.03	Urine	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
29.04	Wound	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
29.05	Sputum	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
29.06	Stool	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
29.07	Others:	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
		[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
		[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	
30.00	Sensitivity				
30.01	Ceftazidime	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.02	Augmentine	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.03	Bactrim	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.04	Tetracycline	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.05	Imipenam	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.06	Sulperazone	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.07	Gentamycin	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.08	Chloramphenicol	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
30.09	Ciprofloxacin	<input type="checkbox"/> Sensitive	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Resistance	<input type="checkbox"/> Not done
31.00	Serology	[1] <input type="checkbox"/> Done	[2] <input type="checkbox"/> Not Done		
31.01	Mixed	1/ <input type="checkbox"/>		1/ <input type="checkbox"/>	
31.02	IgM	1/ <input type="checkbox"/>		1/ <input type="checkbox"/>	
31.03	IgG	1/ <input type="checkbox"/>		1/ <input type="checkbox"/>	
32.00	Polymerase Chain Reaction	[1] <input type="checkbox"/> Positive	[2] <input type="checkbox"/> Negative	[3] <input type="checkbox"/> Not done	





HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### MELIOIDOSIS INVESTIGATION FORM

SECTION B: TO BE COMPLETED BY DISTRICT HEALTH OFFICE

#### 37.00 NOTIFICATION AND CASE CLASSIFICATION

- 37.01 Date of notification  DD  MM
- 37.02 Notification from
- 37.03 Date of investigation  DD  MM
- 37.04 Case classification  
 [1] Suspected  
 [2] Probable  
 [3] Confirmed
- 37.05 Type of case  
 [1] Sporadic  
 [2] Outbreak

#### 38.00 EXPOSURE HISTORY

- 38.01 Date of onset  DD  MM

Movement History During Incubation Period

Date	Activity

- 38.02 Type of exposure  
 [1] Occupational (specify)   
 [2] Recreational (specify)   
 [3] Accidental (specify)   
 [4] Unknown  
 [5] Others (specify)

Date of exposure  DD  MM

- 38.03 Duration of exposure

- 38.04 Mode of transmission  
 [1] Inhalation  
 [2] Direct contact  
 [3] Aspiration  
 [4] Ingestion  
 [5] Unknown  
 [6] Others (Specify)

#### 39.00 OTHER EXPOSED CONTACTS

- 39.01 Number of contacts exposed
- 39.02 Number of contacts examined
- 39.03 Number of contacts with sign & symptoms



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### MELIOIDOSIS INVESTIGATION FORM

#### 40.00 PREVENTION AND CONTROL MEASURES

- 40.01 Active case detection  Done  Not Done
- 40.02 Passive case detection  Done  Not Done
- 40.03 Disinfection  Done  Not Done
- 40.04 Closure of premise  Done  Not Done
- 40.05 Health education  Done  Not Done

#### 41.00 HEALTH EDUCATION ACTIVITIES

- 41.01 Number of health talks given 

--	--	--	--
- 41.02 Number of discussion session 

--	--	--	--
- 41.03 Number of demonstration done 

--	--	--	--
- 41.04 Numbers of pamphlets distributed 

--	--	--	--
- 41.05 Numbers of posters disseminated 

--	--	--	--
- 41.06 Number of banners fixed 

--	--	--	--
- 41.07 Number of press conference 

--	--	--	--
- 41.08 Number of community activities 

--	--	--	--

#### 42.00 ENVIRONMENTAL SAMPLING

- 42.01 Number of water samples  Positive  Negative  Not done
- 42.02 Number of soil samples  Positive  Negative  Not done
- 42.03 Number of air samples  Positive  Negative  Not done
- 42.04 Others (specify) 

--

 Positive  Negative  Not done
- |  |
|--|
|  |
|--|

 Positive  Negative  Not done



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### MELIOIDOSIS INVESTIGATION FORM

43.00 **COMMENTS BY INVESTIGATING OFFICER**

Signature :

Name and designation of reporting officer:

Date :   DD   MM     YYYY

44.00 **COMMENTS BY SUPERVISOR**

Signature :

Name and designation of reporting officer:

Date :   DD   MM     YYYY

45.00 **COMMENTS BY MEDICAL OFFICER OF HEALTH**

Signature :

Name and designation of reporting officer:

Date :   DD   MM     YYYY



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

### 7. Acute Flaccid Paralysis Case Investigation Form, Annex 1, POLIOIx/1-2008

Annex 1

Acute Flaccid Paralysis Case Investigation Form								
Ministry of Health, Malaysia								
1	CASE ID: PEACE	Name:	Gender:	DOB:	Age:	Hospit Regist No.:		
		Mother's N:	Father's N:	District:	State:			
Residential Address:								
2	REFERRAL + REPORTING	Child initially seen at:				Date first seen:		
		Date of report to EPIMOH:			Person reporting:			
Report from where? (Institution):				Attending physician:		Tel. No.:		
Remarks:								
3	HISTORY + PHYSICAL EXAMINATION	Onset of paralysis (date):			No. of days to maximum paralysis:			
		Main history source: 1. Parents 2. Chart 3. Doctor/Nurse						
At onset (paral.): Fever: Y/N   Diarrhoea: Y/N   Cough: Y/N   Other:								
PAST HISTORY (last 30 days):				ON EXAMINATION (date):		SITE OF PARALYSIS:		
Injections?	Yes   No	FLACCID Paralysis?		Yes   No	(grade mot. strength: 0=abs. to 5=full)			
Recent trauma or animal bite?	Yes   No	Meningeal signs (stiff neck):		Yes   No	left arm: _____	right arm: _____		
Any existing neurologic disease?	Yes   No	Paralysis symmetric/asym.?		Symmetric   Asym.	left leg: _____	right leg: _____		
Any recent travel? (Specify below)	Yes   No	Deep tendon reflexes:		Norm.   Red.   Abs.	respir.: yes / no	face: yes / no		
Similar case among contacts?	Yes   No	Any sensory loss?		Yes   No	others (specify): _____			
Remarks:								
4	PRELIMINARY DIAGNOSIS:	IF YES: 1. Poliomyelitis   2. Guillain-Barre   3. Transverse Myelitis   4. Traum. Neuritis   5. Other: ADEM						
		IF NO: 1. Injury   2. Spastic paralysis   3. Joint or bone infection   4. Other: _____						
Name of investigator:		Date: / /			Signature:			
Address of investigator:								
Remarks:								
5	IMMUNISATION HISTORY/ORI	Immunisation card available? Yes / No				Total No. of OPV doses received:		
		Main reason for not fully immunised: 1. not informed 2. illness 3. refusal 4. unknown 5. other: _____						
Dates: OPV1:	OPV2:	OPV3:	OPV4:	OPV5:	OPV6:	OPV7:	Last OPV:	
Recent OPV in contact? Y/N Date				Date 1, outbreak response				
				% of elig				
Remarks:								
6	LAB. INFO.	Date collected:	Date sent:	Date rec. IMR:	Pos. CPE (IMR):	(IMR: PV-Type	Date sent to Ref.:	Ref.-Lab. Result:
		Stool 1: Yes / No			Yes / No	1   2   3	Negative	wild/vacc.   T:   I:   B
Stool 2: Yes / No					Yes / No	1   2   3		wild/vacc.   T:   I:   B
Remarks: Complete Immunizations								
7	FOLLOW-UP	Case examined >= 60 days after onset paralysis? Yes / No				Date of examination:		
		Date: _____ If not seen, why not? _____				Paralysis/Weakness still present? Yes / No		
Site of residual paralysis: Right leg: Y/N   Left leg: Y/N   Right arm: Y/N   Left arm: Y/N   Face: Y/N   Other: _____								
Ability to walk: 1. Cannot walk 2. Walks with assistance 3. Limp 4. Walks normally				Exam. physician:				
Remarks:								
8	FINAL DIAGNOSIS - DATE:	(CONFIRMED POLIO or discarded as polio; Expert Review Committee)						
		1. CONFIRMED > Virus isolation: Yes / No   Residual paralysis: Yes / No   Death: Yes / No   Lost to follow up: Yes / No						
2. DISCARDED		1. Guillain-Barre   2. Transverse Myelitis   3. Traumatic Neuritis   4. Unknown   5. Other						
Remarks:								
NOTE: Please Fax AFP case investigation form to: 1. Dr. Devan Kump, Disease Control Division, MOH (Fax No. 03 - 26946404) 2. Virology Department, Institute for Medical Research (IMR), KL (Fax No: 03 - 26936323) with adequate stool samples. 3. Nearest District Health Office Second AFP Case Investigation form should be sent after 60 days with followup result to the above fax.								





**HOSPITAL MELAKA**

# **PROSEDUR KUALITI**

## **Notifikasi Kes Penyakit Berjangkit**

**No. Pindaan: 00**  
**Tarikh: 15.01.2018**

19. Simptom Dan Tanda-Tanda Penyakit :

### **B. MAKLUMAT KLINIKAL AFP**

Sila rujuk rekod pesakit dan pakar yang merawat kes di hospital dan buat salinan laporan tersebut. Maklumat berikut akan dijadikan sebagai lampiran bersama borang ini.

- Clinical record (Hospital Case Sheets)
  - Laboratory reports
  - Discharge Summary
  - Investigation
- \* Laporan Post Mortem (sekiranya kes mati)

### **C. FOLLOW-UP KES OLEH PAKAR DI HOSPITAL (Jika berkaitan):**

Tarikh F/up	Ulasan Status Perkembangan Keadaan Kes Secara Ringkas



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### D. MAKLUMAT SEJARAH KES & KONTAK

- 1.0 i) Kes ada membuat perjalanan ke Negeri yang endemik Polio (Afghanistan, Pakistan, India, Nigeria, Yemen, Sudan) dalam tempoh 60 hari sebelum onsets kes) : Ya /Tidak
- Jika Ya , Tarikh : \_\_\_\_\_ dan negeri di lawati : \_\_\_\_\_
- ii) Ada kontak dengan orang yang datang dari negara endemik polio dalam tempoh 60 hari sebelum sampel diambil / onsets gejala:
- Ya /Tidak
- Jika Ya , Tarikh : \_\_\_\_\_ dan dari negara: \_\_\_\_\_
- iii) Telah menerima vaksinasi polio dalam tempoh 60 hari sebelum sampel diambil: Ya /Tidak.
- Jika Ya, tarikh diambil:  
Jenis vaksin diambil: OPV / IPV
- iv) Ada kontak dengan mana-mana orang yang baru menerima vaksinasi OPV dalam tempoh 60 hari kebelakangan: Ya /Tidak
- 2.0 i) Nama & Alamat Sekolah/Tadika/Taska/Pusat Asuhan :
- ii) Bilangan kontak ('siblings'/rakan sekolah /jiran) yang mempunyai tanda-tanda sakit yang sama dengan kes (dalam tempoh 60 hari dari tarikh onsets): \_\_\_\_ - \_\_\_\_ orang (Jika ada, sila isikan Jadual Kontak di 4.0)
- 3.0 i) Bilangan di bawah 15 tahun : \_\_\_\_ - \_\_\_\_ orang
- ii) Bilangan yang mempunyai tanda-tanda sakit yang sama dengan kes (dalam tempoh 60 hari dari tarikh onsets) : \_\_\_\_ - \_\_\_\_ orang (Jika ada, sila isikan Jadual Kontak di 4.0)

### 4. Jadual Kontak

Nama Kontak	Umur	Alamat	Hubungan	Status Terkini Kontak
Tiada				

Komen : \_\_\_\_\_



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5. Sejarah Pelalian Kontak (jika sekiranya ada memperolehi imunisasi OPV dalam tempoh 60 hari sebelum onsets kes)(TIDAK BERKENAAN)

Nama Kontak	Umur	Tarikh Vaksinasi	Tempat DiPerolehi

Komen : \_\_\_\_\_

6.0 Senarai kontak yang ada membuat perjalanan ke Negeri yang endemik Polio (Afghanistan, Pakistan, India, Nigeria, Yemen, Sudan, Indon) dalam tempoh 60 hari sebelum onsets kes)

Nama Kontak	Tarikh	Negeri Dilawati	Tempoh Menetap

Komen : \_\_\_\_\_

Komen : \_\_\_\_\_

7.0 Sejarah Pelawat Ke Premis Kes



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Senarai pelawat yang melawat/ tinggal di premis kes dalam tempoh 60 hari sebelum onset (jika ada)

Tarikh	Pelawat	Alamat	Tempoh Menetap	Hubungan

Komen : \_\_\_\_\_

### 8.0 Kebersihan/ Sanitasi Di Persekitaran Premis Kes /Taska/Pusat Asuhan

Kebersihan / Sanitasi	Rumah Kes		Taska/Tadika/Pusat Asuhan	
	Memuaskan	Tidak Memuaskan	Memuaskan	Tidak Memuaskan
i) Dalam Premis				
ii) Luar Premis				
iii) Tandas				
iv) Longkang				
v) Pengurusan Sisa Pepejal				
vi) Kawalan LILATI				
vii) Bekalan Air				
viii) Pengendalian Makanan				

Komen : \_\_\_\_\_



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### 9.0 Langkah Kawalan

Jenis	Rumah Kes		Taska/Tadika/Pusat Asuhan	
	Tarikh	Bahan Digunakan	Tarikh	Bahan Digunakan
i) Disinfeksi				
ii) Kawalan LILATI				

Komen : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 10.0 Pendidikan Kesihatan

Jenis / Cara	Rumah Kes		Taska/Tadika/Pusat Asuhan	
	Tarikh	Bil. Liputan	Tarikh	Bil. Liputan

### 11. Ulasan Pegawai Penyiasat

T/Tangan :

Tarikh :

### 12. Ulasan Pegawai Kesihatan Daerah

### 13. Ulasan Pegawai Epid Negeri



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8. Syndromic Notification Form, Appendix 3, KKM- syndssurv/2003.2

### Appendix 3

*KKM-syndssurv /2003.2*

#### SYNDROMIC NOTIFICATON FORM DISEASE CONTROL DIVISION MINISTRY OF HEALTH MALAYSIA TEL: 03-88834327 FAX: 03-88836271

Reporting A & E / Hospital: .....  
Tel. No.: ..... Fax No: ..... E-mail : .....

Patient's Name : .....

Patient's Address: .....

IC No.: ..... R/N No: .....(if applicable)

Age: ..... Sex: Male / Female Ethnicity: M / C / I / Other

Please state:.....

Admission: ICU / Ward ...../ Mortuary. Date of adm: ..... / ..... / .....

**Please tick the relevant box for the syndrome reported:**

#### CLINICAL SYNDROMES

#### DATE OF ONSET

[dd/mm/yr]

- |                          |                               |
|--------------------------|-------------------------------|
| <input type="checkbox"/> | Acute dermatological syndrome |
| <input type="checkbox"/> | Acute neurological syndrome   |
| <input type="checkbox"/> | Acute respiratory syndrome    |
| <input type="checkbox"/> | Acute haemorrhagic syndrome   |
| <input type="checkbox"/> | Acute jaundice syndrome       |
| <input type="checkbox"/> | Acute diarrhoeal syndrome     |

Working diagnosis: .....

Has the patient been in a foreign country in the last three weeks?

Yes

If yes please state the country (s): .....

No

Name of Reporting Officer: ..... Signature: .....

Designation: ..... Date: .....

*Note: Please fax this form within 24 hours to District Health Office. Thank you.  
(see overleaf for instructions for completing this form and  
the definitions of the syndromes)*





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### 9. KEADAAN KLINIKAL KES

Sila rujuk the WHO AIDS Cases Definition for Surveillance September 1994 dan tandakan dimana berkenaan

- More than 10% body weight loss or cachexia with diarrhea or fever or both, intermittent or constant, for at least 1 month NOT known due to a condition unrelated to HIV Infection
- Cryptococcal meningitis
- Pulmonary or extra-pulmonary tuberculosis
- Kaposi sarcoma
- Neurological impairment that is sufficient to prevent independent daily activities NOT known due to a condition unrelated to HIV infection (e.g. trauma or CVA)
- Candidiasis of the esophagus (which may be presumptively diagnosed based on the presence of oral candidiasis accompanied by dysphagia)
- Clinically diagnosed life threatening or recurrent episode of pneumoniae with OR without etiological confirmation
- Invasive cervical cancer
- Paediatric AIDS (sila nyatakan keadaan klinikal)
- \_\_\_\_\_
- Others (sebutkan)
- \_\_\_\_\_
- \_\_\_\_\_

### 10. JIKA BAYI / KANAK-KANAK BERUMUR KURANG 13 TAHUN

Jenis kelahiran  
(pilih salah satu sahaja)  Spontaneous vaginal delivery (SVD)  
 Assisted vaginal delivery  
 Caeserean section

Status jangkitan HIV ibu  Positif  
 Negatif  
 Tidak diketahui

Jika positif, adakah ibu mengambil ART  Ya  
 Tidak

Jika ya, jenis rawatan  AZT (monotherapy)  
 CART

Jangkamasa rawatan  minggu

Adakah mengambil susu ibu  Ya  
 Tidak

### 11. UNTUK KES KEMATIAN HIV / AIDS

Tarikh kematian        
d d m m y y

Sebab kematian (mengikut ICD 10)

Part I Immediate cause

- a. \_\_\_\_\_  
Due to or consequence of (Intervening cause)
- b. \_\_\_\_\_  
Due to or consequence of (underlying cause)
- c. \_\_\_\_\_

Part II Other significant conditions

(Condition contributing to death but not related to causes given in part Ia)

\_\_\_\_\_

Doktor yang melaporkan \_\_\_\_\_

Wad / Hospital / Klinik \_\_\_\_\_

### 12. CATATAN

\_\_\_\_\_  
\_\_\_\_\_

### 13. MAKLUMAT PELAPOR

Laporan disediakan oleh \_\_\_\_\_ Tandatangan \_\_\_\_\_

Jawatan \_\_\_\_\_

Tarikh \_\_\_\_\_

### Nota

- Laporan ini hendaklah disediakan bagi semua kes yang dikenalpasti dijangkiti HIV/AIDS / meninggal kerana AIDS
- Laporan perlu disediakan oleh Pegawai Perubatan / Kakitangan kesihatan yang menyiasat / mengendalikan kes berkenaan

M Surat 2 / 2



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10. Dog Bite Surveillance, Annex 1a, Interim Guideline For Human Rabies Prevention & Control In Malaysia

Annex 1a

HOSPITAL / KLINIK KERAJAAN & SWASTA  
NAMA HOSPITAL/KLINIK KERAJAAN & SWASTA.....  
DAERAH .....  
NEGERI .....

PEJABAT KESIHATAN DAERAH  
DAERAH.....  
NEGERI .....

Tuan/Puan,

### **BORANG NOTIFIKASI KES GIGITAN HAIWAN YANG MEMBAWA PENYAKIT RABIES**

NAMA PESAKIT	
K/P	
JANTINA	
UMUR	
BANGSA	
NAMA IBU/BAPA	
ALAMAT	
NO LAPORAN POLIS	
NO PESAKIT LUAR	
JENIS HAIWAN	
SILA TANDAKAN (√) DALAM KOTAK YANG SESUAI	BERTUAN ( )    YANG TIDAK BERTUAN ( ) BERLESEN ( )    TAK BERLESEN ( ) TIDAK DIKETAHUI ( )
TARIKH DIGIGIT	
TEMPAT KEJADIAN	
TARIKH & RAWATAN DITERIMA	
MASA RAWATAN	
NAMA PEGAWAI PERUBATAN	
KES DIRAWAT SEBAGAI	PESAKIT LUAR ( ) DIMASUKKAN WAD ( )
ALAMAT HOSPITAL/KLINIK	

NOTA : Borang ini hendaklah diisi oleh pengamal perubatan yang menguruskan kes gigitan anjing/haiwan liar (bagi setiap kes)



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### 11. Borang TBIS 10A-1, Sistem Maklumat Tibi, KKM

TBIS 10A-1

Sistem Maklumat Tibi, Kementerian Kesihatan Malaysia



#### MAKLUMAT PERMULAAN RAWATAN PESAKIT TIBI

**ARAHAN :** Borang ini hendaklah dilengkapkan dan dihantar ke Pejabat Kesihatan Daerah terdekat dalam tempoh 1 minggu dari tarikh diagnosa. Tandakan ✓ di ruangan berkaitan.

A. PUSAT RAWATAN	
1. Nama pusat rawatan yang memulakan rawatan:	2. Nama pusat rawatan yang menyambung rawatan:
<input type="text"/>	<input type="text"/>

B. DATA ASAS PESAKIT	
3. Nama Pesakit (dan nama panggilan jika ada):	4. R/N Pusat Rawatan
<input type="text"/>	<input type="text"/>
5. No. Pengenalan Diri:	6. No. Dokumen Perjalanan:
<input type="text"/>	<input type="text"/>
7. Jantina <input type="checkbox"/> Lelaki <input type="checkbox"/> Perempuan	8. Umur: <input type="text"/> *tahun/bulan
	9. Berat Badan <input type="text"/> kg
10. Taraf Perkahwinan: <input type="checkbox"/> Bujang <input type="checkbox"/> Berkahwin <input type="checkbox"/> Duda/Janda <input type="checkbox"/> Tidak Berkaitan	
11. Tempoh Migrasi (bagi warganegara asing): <input type="text"/> *bulan/tahun (*potong mana yang tidak berkenaan)	

C. ALAMAT PESAKIT		
12. Alamat Tempat Tinggal Semasa (yang boleh dihubungi)	Alamat 1:	Alamat 2:
	<input type="text"/>	<input type="text"/>
13. Penanda Tempat (Landmark):		
14. No. Telefon:		

D. PEKERJAAN PESAKIT	
15. Pekerjaan Utama:	16. Lain-lain Pekerjaan:
<input type="text"/>	<input type="text"/>
17. Jika bertugas di bidang perubatan/kesihatan:	i. Anggota KKM? <input type="checkbox"/> **Ya <input type="checkbox"/> Tidak
	**sila lengkapkan borang WEHU 1
ii. Institusi tempat bertugas:	iii. Bahagian tempat bertugas:
<input type="checkbox"/> Hospital	<input type="checkbox"/> Wad Tibi
<input type="checkbox"/> Poliklinik Masyarakat	<input type="checkbox"/> Makmal Mikrobiologi
<input type="checkbox"/> Klinik Desa	<input type="checkbox"/> Bilik Rawatan Pesakit Luar / Kecemasan
<input type="checkbox"/> Klinik Swasta	<input type="checkbox"/> Klinik Dada
<input type="checkbox"/> Lain-lain Klinik (tentera, PBT, estet dll.)	<input type="checkbox"/> Lain-lain (nyatakan): <input type="text"/>

E. SEJARAH PENYAKIT DAN STATUS KESIHATAN PRA-DIAGNOSA TIBI			
18. Diabetes Mellitus	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak	19. Merokok	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak
20. Cyanotic Heart disease	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak	21. Ketagihan Alkohol	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak
22. Liver Disease	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak	23. Ketagihan Dadah	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak
24. Chronic Renal Failure	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak	25. HIV/AIDS	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak
26. Malabsorption Syndrome	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak	27. Pembedahan Gastrectomy	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak
28. Rawatan Steroid	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak	29. Kanser	<input type="checkbox"/> Ya <input type="checkbox"/> Tidak
30. Lain-lain, nyatakan jika ada:	<input type="text"/>		
Nota kepada Inspektor Kesihatan: Jawapan "Ya" kepada salah satu kenyataan di atas menunjukkan pesakit ada risiko perubatan. Sila penuhi petak D10 yang berkaitan dalam TBIS 10A-3.			



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Sistem Maklumat Tibi, Kementerian Kesihatan Malaysia



### F. PARUT BCG DAN UJIAN TURBEKULIN (UJIAN MANTOUX)

31. Parut BCG :  i. Ada (termasuk Keloid)  ii. Tiada (termasuk pinpoint)

32. Jika tiada, nyatakan nama tempat dilahirkan:

33. Ujian Tuberkulin  i. Dibuat  ii. Tidak Dibuat

34. Jika dibuat, tarikh ujian dibuat:  /  /   
hari bulan tahun

35. Jika dibuat, bacaan:  mm

36. Keputusan:  i. positif  ii. Negatif

Adakah *Brisk*?  Ya  Tidak

Adakah *Blister*?  Ya  Tidak

### G. UJIAN MAKMAL

Sapuan Terus		38. Keputusan (Tandakan √)						
37. Jenis Spesimen		Tiada Keputusan	Tidak Dibuat	Negatif	1-9 AFB/100 (+)	10-99 AFB/100 (1+)	1-10 AFB/50 (2+)	>10 AFB/20 (3+)
i. Kahak	Spot I							
	Pagi I							
	Spot II							
	Pagi II							
	Lain-							
	Lain :							
39. Spesimen Selain kahak (nyatakan)			Positif	Negatif				
ii.								
iii.								
Kultur Untuk AFB - Keputusan Awal (Tandakan √)								
40. Jenis Spesimen		Positif		Negatif		Tercemar / Tidak dibuat		
i. Kahak								
41. Spesimen Selain Kahak (Nyatakan)								
ii.								
iii.								

### H. UJIAN HIV

42. Jenis Ujian:

i. Saringan  Positif / Reaktif  Negatif / Reaktif

Tidak diketahui  Tidak dibuat

ii. Pengesahan  Positif  Negatif

a. No. Ujian:  b. Tarikh:

Tidak dibuat

43. Jika tidak dibuat, mengapa?  Tiada perkhidmatan  Tiada Kebenaran  Lain-lain

### I. UJIAN HISTOPATOLOGI

44. Jenis Ujian:  i. Biopsi Tisu  ii. Fine Needle Aspiration Cytology (FNAC)

45. Keputusan:



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**J. UJIAN RADIOLOGI DAN IMAGING**

46. X-Ray Dada:  Tidak dibuat  Teruk (*Moderately Advanced*)  
 No Lesion  Sangat Teruk (*Far Advanced*)  
 Sederhana (*Minimal*)

47. Lain-lain X-Ray / Imaging: i. Jenis X-Ray/Imaging:

iii. Keputusan:

**K. PERIHAL EPISOD TIBI SEMASA**

48. Cara Pengesanan  
 i.  Aktif  Pemeriksaan Kontak  Kajian Khas  
 ii.  Pasif (Datang Sendiri)  
 iii.  Saringan (nyatakan)  
 Pemeriksaan perubatan untuk pengambilan pekerja  
 Pemeriksaan perubatan untuk melanjutkan pelajaran  
 Saringan pekerja melalui FOMEMA  
 Pemeriksaan pekerja berkala  
 Saringan khas (nyatakan tujuan):

Penjara  
 Pusat Serenti  
 Rumah Orang Tua  
 Klinik AIDS/STI  
 Lain-lain (nyatakan):

49. Simptom Utama (boleh > 1)  
 Batuk melebihi 2 minggu  Demam  
 Batuk Berkahak  Berpeluh malam  
 Batuk Berdarah  Kurang selera makan  
 Susut berat badan  Lain-lain (nyatakan):

50. Klinik pertama dilawati dengan tanda-tanda penyakit Tibi. (jika berbeza dengan pusat yang membuat notifikasi)  
 i. Kemudahan Kerajaan  
 Hospital  Pej. Kesihatan (aktiviti pengesanan kontak)  
 Poliklinik Masyarakat  Pasukan Kesihatan Sekolah  
 Klinik Desa  Klinik di Institusi (Contoh: Pusat Serenti)  
 Klinik Bergerak  Lain-lain:

i. Kemudahan Kerajaan  
 Hospital  Lain-lain (nyatakan):

Klinik Persendirian

i. Nama & Alamat Fasiliti:

ii. Adakah ujian sapuan terus kahak dibuat?  Ya  Tidak  
 Jika Ya, Keputusan:  Positif  Negatif

51. Kategori Kes Tibi  Kes Baru  Kes Setelah Terhenti Rawatan  
 Kes Berulang  Kes Setelah Gagal Rawatan

52. Jika kes Setelah Gagal Rawatan, adakah kes ini kes Tibi Kronik?  Ya  Tidak

53. Lokasi Anatomi Tibi (Diagnosa).  Tibi Pulmonari  
 Tibi Pulmonari dan Ekstrapulmonari  
 Tibi Ekstrapulmonari

54. Jika Ekstrapulmonari, nyatakan nama organ yang terlibat  
 i.  ii.

Adakah, 55. Tibi Meningitis?  Ya  Tidak 56. Tibi Miliari?  Ya  Tidak

57. Diagnosa Penuh (nyatakan):



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Sistem Maklumat Tibi, Kementerian Kesihatan Malaysia



### K. PERIHAL EPISOD TIBI SEMASA (sambungan...)

58. Tempat Membuat Diagnosa:

- Swasta
- Hospital Kerajaan
- Poliklinik Masyarakat
- Klinik Desa

59. Tempat Memulakan Rawatan:

- Swasta
- Hospital Kerajaan
- Poliklinik Masyarakat
- Klinik Desa

60. Tarikh Rawatan Dimulakan:  /  /   
*hari bulan tahun*

61. i. Regim Rawatan Fasa Intensif:

- 2SHRZ
- 2EHRZ
- 2HRZ
- Lain-lain, nyatakan:

ii. Cadangan Regim Rawatan Fasa Sambungan:

- 4<sub>2</sub>H<sub>2</sub>R
- 4S<sub>2</sub>H<sub>2</sub>R<sub>2</sub>
- 4HR
- 4H<sub>3</sub>R
- 4S<sub>3</sub>H<sub>3</sub>R<sub>3</sub>
- Lain-lain, nyatakan:

62. Nama dan  
Tandatangan Doktor:

### L. RAWATAN TIBI EPISOD DAHULU (Bagi Kes Berulang, Terhenti Rawatan dan Gagal Rawatan)

63. Nama dan Alamat Pusat Rawatan Terdahulu:

64. Tarikh Rawatan Dimulakan:  65. Tarikh Rawatan Berakhir:

66. Tempoh Rawatan  \* minggu / bulan (\*potong mana yang tidak berkenaan)

67. No. Daftar Tibi Dahulu:

### M. SENARAI KONTAK YANG TELAH DIPERIKSA (Sila gunakan lampiran jika ruangan tidak mencukupi)

Bil	68. Nama	69. Jantina	70. Umur	71. Alamat Semasa	72. Hubungan	73. Keputusan
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

### N. PELAPOR

74. Nama Pelapor:

75. Tandatangan dan Cop Jawatan

76. Cop Pusat Rawatan

77. Tarikh:  /  /   
*hari bulan tahun*

muka surat 4 / 4



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### 12. Notification Form For Zika Virus, Zika1 /case/2016

Lampiran 3

Zika1 /case/2016



#### NOTIFICATION FORM FOR ZIKA VIRUS

Disease Control Division  
Ministry Of Health Malaysia

1. Reporting Centre		Name of Hospital / Clinic:		State:	
Phone:		Fax:		E-mail:	
2. Information of Patient		Name:		Age: ___yr ___mth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			Phone (Home):		RN No:
Nationality:		Ethnicity: <input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other, specify:			IC No:
<input type="checkbox"/> Malaysian <input type="checkbox"/> Non Malaysian		Country of Origin:			Passport No:
Occupation: <input type="checkbox"/> Health Care Worker <input type="checkbox"/> Others, please state:					Date of symptom onset (dd/mm/yy):
3. Signs and Symptoms		<input type="checkbox"/> Fever <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Malaise <input type="checkbox"/> OTHERS <input type="checkbox"/> Rash <input type="checkbox"/> Myalgia <input type="checkbox"/> Arthralgia			
Temperature on admission: ___°C		<input type="checkbox"/> Other symptoms, specify: _____			
4. Is there any alternative diagnosis that can fully explain patient's illness?					<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Clinical status at time of report		Was patient hospitalised?		Ward:	
<input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> Brought In Dead (BID) Date: _____		<input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> Brought In Dead (BID) Date: _____		<input type="checkbox"/> Isolation ward <input type="checkbox"/> General ward <input type="checkbox"/> ICU	
Progress:		<input type="checkbox"/> On treatment, specify: _____ <input type="checkbox"/> Died Date: _____			
If patient died: Was post mortem performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending					
6. Exposure History					
Has the patient travelled to areas reporting confirmed cases of Zika virus prior to onset of symptoms?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please specify: Country visited:					
Country/State/province visited		Duration of stay		Name of Airline & Flight No/Cruise/Other mode of transportation	
		From [dd/mm/yy] To [dd/mm/yy]			
1.					
2.					
3.					
Date of return to Malaysia:			Entry point:		
7. Similar illness		Anybody in the neighbourhood having similar illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Diagnostic Evaluation		Date taken	Date send to lab	Name of laboratory	Result
Virology					
9. Working diagnosis: (please state)					
10. Reporting Officer:				Signature:	
Designation:			Date:	H/Phone No:	
For District Health Office use only					
11. Active case finding		Has active case finding been initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No Number of people with similar illness:			No. of cases referred to hospital: Number of cases isolated:
12. Investigating Officer:				Signature:	
Designation:			Date:	H/Phone No:	
For Disease Control Division use only					
COMMENTS:					



HOSPITAL MELAKA

# PROSEDUR KUALITI

## Notifikasi Kes Penyakit Berjangkit

No. Pindaan: 00  
Tarikh: 15.01.2018

Lampiran 4

Zika 2/ microcephaly/ 2016



NOTIFICATION FORM  
FOR MICROCEPHALY  
Disease Control Division  
Ministry Of Health Malaysia

1. Reporting Centre		Name of Hospital		State:	
Phone:		Fax:		E-mail:	
2. Information Mothers		Name:		Age: ___yr ___mth	
Address:			Phone (Home):		RN No:
Nationality:		Ethnicity: <input type="checkbox"/> Malay <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other, specify:			IC No:
<input type="checkbox"/> Malaysian <input type="checkbox"/> Non Malaysian		Postnatal Parity:		State:	
Occupation		: <input type="checkbox"/> Health Care Worker <input type="checkbox"/> Others, please state:		Passport No:	
3. Mode of delivery		Baby weight:		4. Mother relevant medical history:	
<input type="checkbox"/> LSCS <input type="checkbox"/> SVD				1. 2. 3. 4. 5.	
5. Congenital abnormalities diagnosed by:			Name:		
6. Congenital abnormalities (ICD10) codes			(based on ICD10) and diagnosis		
7. Clinical status at time of reporting		Was baby hospitalised? <input type="checkbox"/> Yes, date: _____ <input type="checkbox"/> Brought In Dead (BID) Date: _____		Ward: <input type="checkbox"/> Isolation ward <input type="checkbox"/> General ward <input type="checkbox"/> ICU	
				Progress: <input type="checkbox"/> On treatment, specify: _____ <input type="checkbox"/> Died Date: _____	
If patient died: Was post mortem performed?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending			
8. Exposure History		Has the mother travelled to areas reporting confirmed cases of Zika virus during her antenatal <input type="checkbox"/> Yes <input type="checkbox"/> No Date of travelling: From _____ to _____			
		If yes, please specify: Country visited:			
Country/State/province visited		Duration of stay		Name of Airline & Flight No/Cruise/Other mode of transportation	
		From [dd/mm/yr] To [dd/mm/yr]			
1.					
2.					
3.					
Date of return to Malaysia:		Entry point:			
9. Diagnostic Evaluation		Date taken	Date send to lab	Name of laboratory	Result
Virology					
10. Working diagnosis: (please state)					
11. Reporting Officer:				Signature:	
Designation:			Date:	H/Phone No:	
For District Health Office use only					
12. Investigating Officer:				Signature:	
Designation:			Date:	H/Phone No:	
For Disease Control Division use only					
COMMENTS:					