health
Department: Health
REPUBLIC OF SOUTH AFRICA

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

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)}

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 throat	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

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***

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, specify						
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	

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)		

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	

If other, specify

Vaccination history for COVID-19

Has the patient received a COVID-19 vaccine?	Yes	No	Unknown
If yes, how many doses were received?			Unknown
Date of last dose	y y y y - m m - d d		
Name of vaccine			
Source of data on vaccination	Vaccine card	Vaccine register	Patient verbal report

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**