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

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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**