Republic of Malawi Ministry of Health

CBS Reporting form Version 3. 2020

CASE-BASED SURVEILLANCE REPORTING FORM

Reporting Facility:		**Reporting District:**		**Type of Case:**	□OPD □IPD □POE
Reporter Name:		**Reporting Phone #:**		**Reporting Date:**	____ / ____ / _____

Type of Reporting Disease/Condition: □AFP □Cholera □Diarrhoea with blood(Shigellaosis) □Neonantal Tetanus □Measles □Menigitis □Plague □AHFS □Yellow Fever □Rabies □SARS/MERS/COVID □Typhoid fever □AEFI □Anthrax □ILI □SARIs □Dengue fever □Listeriosis □Smallpox □Maternal Death □Monkey Pox □Perinatal Death □Unexplained cluster □Other (*specify*):_____

Last Name of Case:			**First Name of Case:**		
Date of Birth (dd/mm/yyyy)	_____ / _____ / _____		**Age of Case(if DOB unknown):**	year: ____ months:____ days:____	
Nationality:			**Cases UID:**	□**Passport** □**NID** _____	
District of Case Residence:		□**Urban** □**Rural**	**Sex:**	□Male □Female	**Occupation:**
Physical Address:			**Nearest Landmark:**		
Phone number of Case:			**Parent or Care Taker Name:**		
Date Seen at Facility:	_____ / _____ / _____		**Number of Vaccine:** (For case of Measles, NT (TT in mother), Yellow Fever , and Menigitis)		
Date Facility Notified District:	_____ / _____ / _____		**Date of Last Vaccination:**	_____ / _____ / _____	
Recent Travel History:	□Indiginous □International **Where:**_____ **Date of Return:** _____ / _____ / _____				
Any contact with OT case:	□No □Suspected □Confirmed		**Any Clustering:**	□No □Family □School □Hospital □Workplace	
Date of Onset:	_____ / _____ / _____		**Pregnancy** (if case if female)**:**	□Yes □No	**Trimaster:**
Presenting Symptom(s), tick if any presented:	□No(Asymptomatic) □Fever □Cough □Headache □Muscle ache □Vomit □Nausea □Diarrhea □ Fatigue □Abdominal pain □Chest pain □ Shortness of Breath □Bleeding □Skin rash □Other:_____				
Underlying Condition(s), tick if any presented:	□No □Diabetes □Hypertention □HIV □COPD □Tuberculosis □Stroke □Asthma □Cancer □Liver disease □Kidney disease □Cardiovascular disease □Neurological disease □Mental □Other:_____				
Person Completer Form:	Name_____ Function: _____ Signature:_____				

For health Faiclity: If lab specimien is collected, complete the following information. And send a copy of this form to the lab with spcimen.

Date specimen collected:	_____ / _____ / _____	**Date specimen sent to lab:**	_____ / _____ / _____
Specimen type:	□Blood □Plasma □Serum □Aspirate □CSF □Pus □Saliva □Biopsy □Stool □Urethral/Vaginal discharge □Urine □Sputum □NP swab □OP swab □NP swab □Food sample □Water sample		

For the lab: Complete this section and return the form to district team and clinician / confirm the result is apearing in the National LIMS

Specimen condition	□Adequate □Not Adequate	**Date lab received specimen:**	_____ / _____ / _____
Type of test(s) performed:		**Testing Platform:**	
Final Laboratory Result:	□**P**ostive □**N**egative	**Date lab sent result to district:**	_____ / _____ / _____
Date result sent to HCW:	_____ / _____ / _____	**Date district received result:**	_____ / _____ / _____

Case Final Outcome:	□**A**live □**D**ead □**TO** □**L**ost	**Case Final Classification:**	□**C**onfirm □**P**robable □**C**ompatible □**D**iscarded