FORM: EPID/37/5R2004

**WEEKLY REORTING FORM FOR AFP\*, MEASSLES, RUBELLA/CRS CASES FROM**

**HOSPITALS**

**(SENTINAL SITES)**

**INSTITUTION:**

**Week of reporting: (Saturday to Friday) : Week No:-**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Disease** | **Name of the Patient** | **Age** | **Sex** | **Ward** | **B.H.T. No** | **\*\*D.O.A.** | **Date of Onset** | **Residential Address** |
|  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |

Name: ………………………………………………….. Signature: ………………………………………………….. Date: …………………………………………………..

\* AFP – Acute Flaccid Paralysis

\*\* D.O.A. – Date of Admission

This form should be completed for all cases of **AFP, MEASSLES and RUBELLA /CRS** after visiting Medical, Pediatric, EYE, ENT and Neurology wards during the week. Even if no cases have been detected, please forward this return every Friday to **Epidemiologist, Epidemiological Unit,** **231, de saram place, Colombo 01000** with a copy to Regional Epidemiologist, **Tel: 2695112, Fax : 2696583**,

E-mail: [epidunit@sltnet.lk / chepid@sltnet.lk](mailto:epidunit@sltnet.lk%20/%20chepid@sltnet.lk) by Head of institution/ICNO/PHI or any other identified officer.