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| * This form is for notification of confirmed or suspected cases of acute rheumatic fever (arf).
* Chronic heart disease in the absence of acute features of ARF is not notifiable.
* **NOTE:** Notification does not facilitate referral to the Rheumatic Fever Registration and delivery of IM penicillin.
 |
| **Notification Details** | [ ]  Primary care practitioner | [ ]  Hospital practitioner | [ ] Other |
| **Name of person notifying**  | **Add name** | **Date reported** | **Click for date** |
| **Organisation** | **Enter organisation name** | **Phone** | **Organisation phone** |
| **Usual GP & Practice** | **GP name** | **GP Phone** | **GP phone** |
| **NOTIFICATION TYPE** | [ ]  Initial attack | [ ]  Recurrent attack | No. previous attacks **Insert number** |
| **CASE STATUS****As per NHF case definitions** | [ ]  Definite | [ ]  Probable | [ ] Suspected  |
| **Patient details and risk factors** |
| **Name of case** | **Surname** | **Given name(s)** |
| **NHI number** | **Add NHI #** | **Date of birth** | **Add DOB** | **Gender** | **Select from list** |
| **Address** | **Add address** |
| **Email address** | **Add email** |
| **Phone (home)** | **Add phone #** | **Phone (work)** | **Add alt #** | **Mobile** | **Add mobile #** |
| **Ethnicity** | **Choose an item** | **Other, please specify** |
| **If Maori please specify Iwi** |
| **Attends ELS or School:** | [ ] Yes | [ ]  No | **If Yes, name & area of facility: Add name and area** |
| **Family history of ARF?** | [x] Yes | [x]  No |  |
| **CLINICAL ASSESSMENT** |
| **Onset of ARF Symptoms** | **Select date** |  |
| **Evidence of preceding GAS infection****Leave blank if not present/not done** | [ ]  Elevated or rising antibody titre | [ ]  Positive throat culture for GAS | [ ]  Positive rapid strep antigen test |
| **Major manifestations****Select all that apply** | [ ]  Carditis | [ ]  Polyarthritis | [ ]  Aseptic monoarthritis |
| [ ]  Chorea | [ ]  Subcutaneous nodules | [ ]  Erythema marginatum |
| **Minor manifestations****Select all that apply** | [ ]  Arthralgia | [ ]  Fever | [ ]  Elevated ESR |
| [ ]  Positive CRP | [ ]  Prolonged PR interval |  |
| **REFERRALS** |
| **Healthy Homes {AWHI, Noho Ahuru)** | [ ] Yes | [ ]  No | [ ]  Not eligible  | If yes, add date **Select date** |
| **Dental service** | [ ] Yes | [ ]  No |  |  |
| **Community nursing** | [ ] Yes | [ ]  No |  |  |
| **Additional Comments** |
| **Add comments here** |

**Thank you for completing this form. You may be contacted by ARPHS for further information.
Email to ARPHS at** **notify@adhb.govt.nz**