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

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 by Head of institution/ICNO/PHI or any other identified officer.