

Infectious Diseases (Notification of Infectious Diseases) Regulations

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INFECTIOUS DISEASES ACT (CHAPTER 137, SECTIONS 6 AND 72(1)(f))

INFECTIOUS DISEASES (NOTIFICATION OF INFECTIOUS DISEASES) REGULATIONS

Rg 4

G.N. No. S 394/2001

REVISED EDITION 2002

(31st January 2002)

[1st September 2001]

Citation

1. These Regulations may be cited as the Infectious Diseases (Notification of Infectious Diseases) Regulations.

Form of notification

2. The form of notification of an infectious disease to be given under section 6 of the Act shall be in the form set out in the First Schedule.

Person to be notified

3. For the purposes of section 6 of the Act, notification of an infectious disease shall be treated as having been given to the Director if the notification is given —

- (a) in the case of an infectious disease referred to in Part I or II of the Second Schedule, to the Commissioner;
- (b) in the case of an infectious disease referred to in Part III of the Second Schedule, to the Head of the Department of Clinical Epidemiology; and
- (c) in the case of an infectious disease referred to in Part IV of the Second Schedule, to the Assistant Director of the Department of Sexually Transmitted Diseases Control Clinic.

Time and manner of notification

4.—(1) Unless the Commissioner otherwise allows —

- (a) notification of an infectious disease shall be given —
 - (i) in the case of an infectious disease referred to in Part I of the Second Schedule, not later than 24 hours from the time of diagnosis of such disease; and
 - (ii) in the case of an infectious disease referred to in Part II of the Second Schedule, not later than 72 hours from the time of diagnosis of such disease; and
- (b) such notification shall be given by facsimile transmission or through an electronic notification system set up for such notification.

(2) Unless the Director otherwise allows —

- (a) notification of an infectious disease referred to in Part III or IV of the Second Schedule shall be given not later than 72 hours from the time of diagnosis of such disease; and
- (b) such notification shall be given by facsimile transmission or through an electronic notification system set up for such notification.

FIRST SCHEDULE

MD 131

INFECTIOUS DISEASES ACT
(CHAPTER 137)

Regulation 2

INFECTIOUS DISEASES
(NOTIFICATION OF INFECTIOUS DISEASES)
REGULATIONS

NOTIFICATION OF INFECTIOUS DISEASES UNDER SECTION 6

PARTICULARS OF PATIENT (Please appropriate box where applicable)		NRIC No./Passport No./Foreign Identification Number (FIN)																	
Name of Patient (BLOCK LETTERS) _____		<table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (dd/mm/yyyy) _____	Ethnic Group <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Malay <input type="checkbox"/> Others	Residential Status <input type="checkbox"/> Resident <input type="checkbox"/> Non-Resident																
Residential Address _____		Occupation _____																	
Place of Work/School/Child Care Centre/Kindergarten _____		Telephone No. _____ Home _____ Office/HQ/PG _____																	
DISEASE DIAGNOSED (CLINICAL OR LABORATORY DIAGNOSIS)																			
To ENAB NOT LATER THAN 24 HOURS FROM TIME OF DIAGNOSIS		FAX NO. 7348287 OR 7319138																	
<table style="width: 100%;"> <tr> <td><input type="checkbox"/> 1. Cholera</td> <td><input type="checkbox"/> 5. Haerd, list and mouth disease</td> <td><input type="checkbox"/> 9. Paratyphoid</td> <td><input type="checkbox"/> 13. Others (Specify) _____</td> </tr> <tr> <td><input type="checkbox"/> 2. Dengue</td> <td><input type="checkbox"/> 6. Leptospirosis</td> <td><input type="checkbox"/> 10. Plague</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 3. Dengue haemorrhagic fever</td> <td><input type="checkbox"/> 7. Malaria</td> <td><input type="checkbox"/> 11. Typhoid</td> <td></td> </tr> <tr> <td><input type="checkbox"/> 4. Encephalitis</td> <td><input type="checkbox"/> 8. Nipah virus infection</td> <td><input type="checkbox"/> 12. Yellow fever</td> <td></td> </tr> </table>				<input type="checkbox"/> 1. Cholera	<input type="checkbox"/> 5. Haerd, list and mouth disease	<input type="checkbox"/> 9. Paratyphoid	<input type="checkbox"/> 13. Others (Specify) _____	<input type="checkbox"/> 2. Dengue	<input type="checkbox"/> 6. Leptospirosis	<input type="checkbox"/> 10. Plague		<input type="checkbox"/> 3. Dengue haemorrhagic fever	<input type="checkbox"/> 7. Malaria	<input type="checkbox"/> 11. Typhoid		<input type="checkbox"/> 4. Encephalitis	<input type="checkbox"/> 8. Nipah virus infection	<input type="checkbox"/> 12. Yellow fever	
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<small>For any disease not appearing in this form which may be of an infectious nature and is report in an epidemic, please in disease is not known, please specify diagnosis.</small>																			
To ENAB NOT LATER THAN 72 HOURS FROM TIME OF DIAGNOSIS		FAX NO. 7348287 OR 7319138																	
<table style="width: 100%;"> <tr> <td><input type="checkbox"/> #14. Chickenpox</td> <td><input type="checkbox"/> 15. Hepatitis, viral</td> <td><input type="checkbox"/> #18. Mumps</td> <td><input type="checkbox"/> #20. Rubella</td> </tr> <tr> <td><input type="checkbox"/> #15. Diphtheria</td> <td><input type="checkbox"/> #17. Measles</td> <td><input type="checkbox"/> #19. Polio/myelitis</td> <td></td> </tr> </table>				<input type="checkbox"/> #14. Chickenpox	<input type="checkbox"/> 15. Hepatitis, viral	<input type="checkbox"/> #18. Mumps	<input type="checkbox"/> #20. Rubella	<input type="checkbox"/> #15. Diphtheria	<input type="checkbox"/> #17. Measles	<input type="checkbox"/> #19. Polio/myelitis									
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If for notifiable diseases marked #, please provide vaccination history : <input type="checkbox"/> Yes - if yes, Date of vaccination (dd/mm/yyyy) _____ <input type="checkbox"/> No																			
To DOCS NOT LATER THAN 72 HOURS FROM TIME OF DIAGNOSIS		FAX NO. 2541615																	
<input type="checkbox"/> 21. AIDS <input type="checkbox"/> 22. HIV infection (non-AIDS) <input type="checkbox"/> 23. Tuberculosis																			
<small>For Tuberculosis, the Tuberculosis Notification Form MD 230-92 should also be completed.</small>																			
To DOCS NOT LATER THAN 72 HOURS FROM TIME OF DIAGNOSIS		FAX NO. 2594335																	
<table style="width: 100%;"> <tr> <td><input type="checkbox"/> 24. Chancroid</td> <td><input type="checkbox"/> 27. Non-infectious syphilis (latent/tertiary)</td> <td><input type="checkbox"/> 30. Genital herpes (first episode)</td> </tr> <tr> <td><input type="checkbox"/> 25. Gonorrhoea</td> <td><input type="checkbox"/> 28. Infectious syphilis (primary/secondary)</td> <td><input type="checkbox"/> 31. Genital herpes (recurrent)</td> </tr> <tr> <td><input type="checkbox"/> 26. Non-gonococcal urethritis</td> <td><input type="checkbox"/> 29. Congenital syphilis</td> <td><input type="checkbox"/> 32. Leprosy</td> </tr> </table>				<input type="checkbox"/> 24. Chancroid	<input type="checkbox"/> 27. Non-infectious syphilis (latent/tertiary)	<input type="checkbox"/> 30. Genital herpes (first episode)	<input type="checkbox"/> 25. Gonorrhoea	<input type="checkbox"/> 28. Infectious syphilis (primary/secondary)	<input type="checkbox"/> 31. Genital herpes (recurrent)	<input type="checkbox"/> 26. Non-gonococcal urethritis	<input type="checkbox"/> 29. Congenital syphilis	<input type="checkbox"/> 32. Leprosy							
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<small>For venereal diseases marked, full name, NRIC/Passport No./FIN, address and telephone number need not be completed. Initials of the patient should be given.</small>																			
<small>Circle as appropriate</small>																			
Diagnosis <input type="checkbox"/> Clinical <input type="checkbox"/> Confirmed by laboratory tests	Date of onset of illness (dd/mm/yyyy) <table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>											Follow-up of patient <input type="checkbox"/> Treated as outpatient <input type="checkbox"/> Referred to Communicable Disease Centre <input type="checkbox"/> Referred to Dept. of HIV Control Centre, Myanmar Lane <input type="checkbox"/> Others (specify) _____							
Travel History over the past one month From (dd/mm/yyyy) _____ to _____ Countries visited: _____																			
PARTICULARS OF INFORMANT																			
Name of Medical Practitioner/Scientist (BLOCK LETTERS) _____		Signature and Date _____	Physician Code (MCR No.) <table border="1" style="width: 100%; height: 20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																
Name and Address of Clinic/Hospital/Institution/Laboratory _____		Telephone Number _____																	

SECOND SCHEDULE

Regulations 3 and 4

INFECTIOUS DISEASES