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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?** | Yes | | | 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**](mailto:notify@adhb.govt.nz)