|  |  |  |
| --- | --- | --- |
| Nazwa i adres komórki organizacyjnej zakładu leczniczego/praktyki lekarskiej1) | **ZLK-1**  **Zgłoszenie podejrzenia lub rozpoznania(**\*) **zakażenia lub choroby zakaźnej**2) | Adresat:  **Państwowy Powiatowy/Graniczny(**\*) **Inspektor Sanitarny**  **w** ........................................................ |
| **Resortowy kod identyfikacyjny podmiotu leczniczego**3)  Część I. Numer księgi rejestrowej   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |   Część II. TERYT   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |   Część VII. Komórka organizacyjna   |  |  |  |  | | --- | --- | --- | --- | |  |  |  |  | | **Uwagi**:  1) W przypadku dokumentu sporządzonego w postaci papierowej dane mogą być naniesione na dokument  w formie pieczątki albo nadruku.  2)  Nie dotyczy zachorowań na gruźlicę i AIDS, zakażeń HIV oraz podejrzeń lub rozpoznań zachorowań na kiłę, rzeżączkę, chlamydiozy przenoszone drogą płciową – zgłaszanych na innych formularzach.  3) Wypełnić zgodnie z rozporządzeniem Ministra Zdrowia z dnia 17 maja 2012 r. w sprawie systemu  resortowych kodów identyfikacyjnych oraz szczegółowego sposobu ich nadawania (Dz. U. z 2019 r. poz. 173).  4) Wypełnić w przypadku, gdy osobie nie nadano numeru PESEL, wpisując serię i numer paszportu albo  nazwę, numer identyfikacyjny innego dokumentu, na podstawie którego jest możliwe ustalenie danych  osobowych.  (\*) Niepotrzebne skreślić. | |
| **I. ROZPOZNANIE/PODEJRZENIE(**\*)  **1. Kod ICD-10 2. Określenie słowne**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  | – |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |     **3. Data rozpoznania/podejrzenia**(\*) (dd/mm/rrrr) **4. Data zachorowania/wystąpienia pierwszych objawów**(\*) (dd/mm/rrrr)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |   **5. Podstawa rozpoznania/podejrzenia**(\*)  objawy kliniczne (wpisać jakie)……………………………………………………………………………………………………..   |  | | --- | |  |     badania serologiczne (wpisać jakie)………………………………………………………………………………………………   |  | | --- | |  |   badania mikrobiologiczne (wpisać jakie)……………………………………………………………………………………………   |  | | --- | |  |   badanie molekularne (wpisać jakie)…………………………………………………………………………………………………   |  | | --- | |  |   inne badania laboratoryjne (wpisać jakie)………………………………………………………………………………………….   |  | | --- | |  |   przesłanki epidemiologiczne (np. kontakt z zakażoną osobą, zachorowania z ogniska)…………………………………………………………………..   |  | | --- | |  |   inna (wpisać jaka)…………………………………………………………………………………………………………………....   |  | | --- | |  |   **Miejsce pobytu w okresie zachorowania (wystąpienia/stwierdzenia objawów)**:  **6. Województwo 7. Powiat 8. Gmina**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **9. Miejscowość 10. Kod pocztowy**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | - |  |  |  |   **11. Ulica 12. Nr domu 13. Nr lokalu**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **14. Osoba bezdomna**   |  |  |  | | --- | --- | --- | |  | Tak (w pkt 6–9 podać województwo, powiat, gminę i miejscowość) |  | | | |
| **II. Dane PACJENTA**  **1. Nazwisko**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **2. Imię 3. Data urodzenia** (dd/mm/rrrr) **4. Nr PESEL**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **5. Nazwa i numer identyfikacyjny dokumentu**4) **6. Płeć (M, K) 7. Obywatelstwo**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **8. Osoba bezdomna**   |  |  |  | | --- | --- | --- | |  | Tak (w pkt 9–12 podać województwo, powiat, gminę i miejscowość) |  |   **Adres miejsca zamieszkania** (wypełnić, jeżeli inny niż miejsce pobytu w okresie zachorowania)  **9. Województwo 10. Powiat 11. Gmina**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **12. Miejscowość 13. Kod pocztowy**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | - |  |  |  |   **14. Ulica 15. Nr domu 16. Nr lokalu**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   **17. Dane kontaktowe** (wypełnić w przypadku gdy pacjent lub jego przedstawiciel ustawowy wyraża na to zgodę):  Telefon kontaktowy:……………………………………………………………………..  E-mail:……………………………………………………………………………………... | | |
| **III. DANE UZUPEŁNIAJĄCE**  **1. Szczepienia** (dotyczy choroby będącej przedmiotem zgłoszenia, której można zapobiegać drogą szczepień):  Tak (podać liczbę dawek i datę ostatniego szczepienia)……………………………………………………………………………………………………..   |  | | --- | |  |   Nie   |  | | --- | |  |   **2**. **Nazwa i adres miejsca pracy lub nauki** (w szczególności: żłobek, przedszkole, szkoła lub inne):…………………………………………………………………………………………………………………  **3. Dalsze leczenie:**  **1) pozostaje w leczeniu ambulatoryjnym:**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Tak |  | Nie |  |  |  |  |   **2) skierowany do szpitala:**  Tak (podać miejsce planowanej hospitalizacji, o ile jest znane) …………………………………………………………………………………………….   |  | | --- | |  |   Nie   |  | | --- | |  |   **4. Zakażenie szpitalne**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Tak |  | Nie |  |  |  |  |   **5. Pobyt za granicą w okresie narażenia**  Tak(podać miejsce pobytu/ów za granicą, datę wyjazdu oraz powrotu do Rzeczypospolitej Polskiej)…………………………………………………   |  | | --- | |  |   ……………………………………………………………………………………………………………………………………………………………………….  Nie   |  | | --- | |  |   **6. Przypadek importowany**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Tak |  | Nie |  |  |  |  | | | |
| **IV. DANE ZGŁASZAJĄCEGO LEKARZA/FELCZERA**(wpisać albo nanieśćnadrukiem albo pieczątką)    1. Imię i nazwisko............................................................... ……………. 2. Numer prawa wykonywania zawodu: .................................... 3. Podpis ........................................  4. Telefon kontaktowy: ......................................................................... 5. E-mail: ....................................................................... | | |