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| 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

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Część II. TERYT

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Część VII. Komórka organizacyjna

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 | **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 systemuresortowych 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 danychosobowych.(\*) Niepotrzebne skreślić. |
| **I. ROZPOZNANIE/PODEJRZENIE(**\*)**1. Kod ICD-10 2. Określenie słowne**

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 **3. Data rozpoznania/podejrzenia**(\*) (dd/mm/rrrr) **4. Data zachorowania/wystąpienia pierwszych objawów**(\*) (dd/mm/rrrr)

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**5. Podstawa rozpoznania/podejrzenia**(\*) objawy kliniczne (wpisać jakie)……………………………………………………………………………………………………..

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 badania serologiczne (wpisać jakie)………………………………………………………………………………………………

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badania mikrobiologiczne (wpisać jakie)……………………………………………………………………………………………

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badanie molekularne (wpisać jakie)…………………………………………………………………………………………………

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inne badania laboratoryjne (wpisać jakie)………………………………………………………………………………………….

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przesłanki epidemiologiczne (np. kontakt z zakażoną osobą, zachorowania z ogniska)…………………………………………………………………..

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inna (wpisać jaka)…………………………………………………………………………………………………………………....

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**Miejsce pobytu w okresie zachorowania (wystąpienia/stwierdzenia objawów)**:**6. Województwo 7. Powiat 8. Gmina**

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**9. Miejscowość 10. Kod pocztowy**

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**11. Ulica 12. Nr domu 13. Nr lokalu**

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**14. Osoba bezdomna**

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|  | Tak (w pkt 6–9 podać województwo, powiat, gminę i miejscowość) |  |

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| **II. Dane PACJENTA****1. Nazwisko**

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**2. Imię 3. Data urodzenia** (dd/mm/rrrr) **4. Nr PESEL**

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**5. Nazwa i numer identyfikacyjny dokumentu**4) **6. Płeć (M, K) 7. Obywatelstwo**

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**8. Osoba bezdomna**

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|  | 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**

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**12. Miejscowość 13. Kod pocztowy**

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**14. Ulica 15. Nr domu 16. Nr lokalu**

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**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)……………………………………………………………………………………………………..

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**2**. **Nazwa i adres miejsca pracy lub nauki** (w szczególności: żłobek, przedszkole, szkoła lub inne):…………………………………………………………………………………………………………………**3. Dalsze leczenie:****1) pozostaje w leczeniu ambulatoryjnym:**

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|  | Tak |  | Nie |  |  |  |  |

**2) skierowany do szpitala:**Tak (podać miejsce planowanej hospitalizacji, o ile jest znane) …………………………………………………………………………………………….

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**4. Zakażenie szpitalne**

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|  | Tak |  | Nie |  |  |  |  |

**5. Pobyt za granicą w okresie narażenia** Tak(podać miejsce pobytu/ów za granicą, datę wyjazdu oraz powrotu do Rzeczypospolitej Polskiej)…………………………………………………

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**6. Przypadek importowany**

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|  | Tak |  | Nie |  |  |  |  |

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| **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: ....................................................................... |