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Date received by DOH

GOVERNMENT OF WESTERN AUSTRALIA

Department of **Health**

Notification form

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Notification ID

You may notify by post, telephone or fax
To: Communicable Disease Control Directorate,
PO Box 8172, Perth Business Centre WA 6849
Phone: (08) 9388 4852 or Fax: (08) 9388 4848
For urgent ☎ diseases after hours: Phone (08) 9328 0553

PATIENT DETAILS

Family name ____________________

Given name ____________________

Street address ____________________

Suburb/Town ____________________ **Postcode** __________

Tel. Home ____________________ **Mobile** ____________________

Sex ☐ Male ☐ Female **Date of birth** ___/___/_____ (dd mm yyyy)

Country of birth ☐ Australia ☐ Other, specify ____________________

Language spoken at home ☐ English ☐ Other, specify ____________________

Occupation or name of school/childcare centre attended:

____

Does the patient identify as being of Aboriginal and/or Torres Strait Islander origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(For persons of both Aboriginal and Torres Strait Islander origin, tick both 'yes' boxes.)

DISEASE DETAILS

How was the infection identified?

☐ Clinical presentation ☐ Contact tracing ☐ Screening

Date of onset ___/___/_____ (dd mm yyyy) **Date of death** (if applicable) ___/___/_____ (dd mm yyyy)

Place infection acquired ☐ WA ☐ Interstate ☐ Overseas ☐ Unknown

If acquired interstate/overseas, specify ____________________

Was the patient hospitalised? ☐ No ☐ Yes

How was diagnosis made?

☐ Lab ☐ Result pending ☐ Linked to lab-confirmed case ☐ Clinical only

↳ Method: ____________________ Result: ____________________

FOLLOW-UP (tick one or more)

☐ Patient/carer aware of diagnosis and that it is a notifiable disease.
☐ Risk to contacts discussed with patient.
☐ Patient/carer aware Public Health Unit may contact them for information.
☐ Other ____________________

CLINICAL COMMENTS (risk factors, presentation, treatment)

NOTIFIER DETAILS

Name .... **Phone** ....

Clinic/Hospital ....

Address ....

.... **Postcode** ....

Signature .... **Date** ..../......./....... (dd mm yyyy)

NOTIFIABLE INFECTIOUS DISEASES (tick box below) ☑

WA Health Act (1911). Please notify diseases marked with a ☎ by telephone, plus food-borne illness (2 or more linked cases), and enteric infection in a food handler, health professional or child care worker. Otherwise fax or post notification.

- ☎ ☐ Anthrax
- ☎ ☐ Arboviral encephalitis (MVE, Kunjin, JE, other) __________
- ☐ Barmah Forest virus infection
- ☎ ☐ Botulism (food-borne)
- ☐ Brucellosis
- ☐ *Campylobacter* infection Species: __________
- ☐ Chancroid (soft sore)
- ☐ Chikungunya virus infection
- ☐ Chlamydia (sexually acquired)
- ☎ ☐ Cholera
- ☎ ☐ Coronavirus infection ☐ MERS ☐ SARS
- ☐ Creutzfeldt-Jakob disease (classical or variant)
- ☐ Cryptosporidiosis
- ☐ Dengue fever
- ☎ ☐ Diphtheria
- ☐ Donovanosis (*Granuloma inguinale*)
- ☐ Gonorrhoea
- ☎ ☐ Haemolytic uraemic syndrome
- ☎ ☐ *Haemophilus influenzae* type b infection (invasive)
- ☎ ☐ Hepatitis A
- ☐ Hepatitis B ☐ Newly acquired (<2 yrs) ☐ Carrier/unspecified
- ☐ Hepatitis C ☐ Newly acquired (<2 yrs) ☐ Unspecified
- ☐ Hepatitis (other) ☐ D ☐ E
- ☐ HIV/AIDS – use separate form
- ☐ Influenza ☐ A ☐ B
- ☎ ☐ Legionellosis ☐ Longbeachae ☐ Pneumophila ☐ Other
- ☐ Leprosy
- ☐ Leptospirosis
- ☎ ☐ Listeriosis
- ☎ ☐ Lyssavirus infection ☐ Rabies ☐ ABL ☐ Other __________
- ☐ Malaria Species: __________
- ☎ ☐ Measles
- ☐ Melioidosis
- ☎ ☐ Meningococcal infection ☐ Meningitis ☐ Septicaemia ☐ Other
- ☐ Mumps
- ☎ ☐ Paratyphoid fever
- ☐ Pertussis
- ☎ ☐ Plague
- ☐ Pneumococcal infection (invasive)
- ☎ ☐ Poliomyelitis
- ☐ Psittacosis (ornithosis)
- ☐ Q fever
- ☐ Rheumatic fever (acute) – use separate form
- ☐ Rickettsial infection (typhus) Species: __________
- ☐ Ross River virus infection
- ☐ Rotavirus infection
- ☐ Rubella ☐ Non-congenital ☐ Congenital
- ☐ *Salmonella* infection
- ☐ Schistosomiasis
- ☎ ☐ Shiga toxin/verotoxin producing *E.coli* (STEC/VTEC) infection
- ☐ Shigellosis Species: __________
- ☎ ☐ Smallpox
- ☐ Syphilis ☐ 1° ☐ 2° ☐ Early latent (<2yrs) ☐ Late latent ☐ 3° ☐ Congenital
- ☎ ☐ Tetanus
- ☐ Tuberculosis
- ☎ ☐ Tularaemia
- ☎ ☐ Typhoid fever
- ☐ Varicella-zoster virus ☐ Chickenpox ☐ Shingles ☐ Unspecified
- ☐ *Vibrio parahaemolyticus* infection
- ☎ ☐ Viral haemorrhagic fevers (Crimean-Congo, Ebola, Lassa, Marburg)
- ☎ ☐ Yellow fever
- ☐ *Yersinia* infection

VACCINATION STATUS (if applicable)

Has your patient been vaccinated for this disease? ☐ Yes ☐ No

If yes and not recorded on ACIR (e.g. adult), specify below ☐ Unknown

Vaccine (Specify generic or proprietary name)	**Date administered**	**Validation**
1.	/ /	☐ Medical or health record ☐ Self-recall
2.	/ /	☐ Medical or health record ☐ Self-recall

☐ Tick this box if you require more forms and pre-paid envelopes (or print from www.public.health.wa.gov.au/3/522/3/forms.pm).

August 2014

Department of
Health

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ADDITIONAL NOTES:

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