

PATIENT DETAILS

Surname _____ First Name _____ Date of birth ____/____/____ Age _____ HRN _____ Male Female
 Address or Community _____ Telephone _____ Postcode
Indigenous status Aboriginal / Torres Strait Islander / Aboriginal and Torres Strait Islander / Non-Indigenous / Not stated

Doctor notifiable diseases

(please tick one or more)

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> ☎ Haemophilus influenzae type b (invasive) | <input type="checkbox"/> ☎ Pertussis |
| <input type="checkbox"/> ☎ Acute post-streptococcal glomerulonephritis | <input type="checkbox"/> Hepatitis B: newly acquired | <input type="checkbox"/> ☎ Plague |
| <input type="checkbox"/> Adverse vaccine reactions | <input type="checkbox"/> Hepatitis B: chronic | <input type="checkbox"/> ☎ Poliomyelitis |
| <input type="checkbox"/> ☎ Anthrax | <input type="checkbox"/> Hepatitis B: unspecified | <input type="checkbox"/> ☎ Rabies |
| <input type="checkbox"/> ☎ Australian Bat Lyssavirus | <input type="checkbox"/> Hepatitis C: newly acquired | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> ☎ Avian influenza | <input type="checkbox"/> Hepatitis C: chronic | <input type="checkbox"/> First episode |
| <input type="checkbox"/> ☎ Botulism | <input type="checkbox"/> Hepatitis C: unspecified | <input type="checkbox"/> Recurrence |
| <input type="checkbox"/> ☎ Chancroid | <input type="checkbox"/> Hepatitis not otherwise specified | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> ☎ Hepatitis (acute viral) | <input type="checkbox"/> ☎ Severe Acute Respiratory Syndrome (SARS) |
| <input type="checkbox"/> ☎ Cholera | <input type="checkbox"/> HTLV 1 | <input type="checkbox"/> ☎ Smallpox |
| <input type="checkbox"/> Congenital Rubella Syndrome | <input type="checkbox"/> - Adult T cell leukaemia/lymphoma | <input type="checkbox"/> Syphilis < 2 years duration |
| <input type="checkbox"/> Congenital syphilis | <input type="checkbox"/> - Tropical spastic paraparesis | <input type="checkbox"/> Syphilis > 2 years duration |
| <input type="checkbox"/> Creutzfeldt-Jakob Disease | <input type="checkbox"/> ☎ Japanese Encephalitis | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Dengue virus infection (☎ if suspected to be NT acquired) | <input type="checkbox"/> ☎ Kunjin virus infection | <input type="checkbox"/> ☎ Thrombotic thrombocytopenic purpura (TTP) |
| <input type="checkbox"/> ☎ Diphtheria | <input type="checkbox"/> Leprosy | <input type="checkbox"/> ☎ Tuberculosis |
| <input type="checkbox"/> Donovanosis | <input type="checkbox"/> Lymphogranuloma venereum (LGV) | <input type="checkbox"/> ☎ Tularaemia |
| <input type="checkbox"/> ☎ Food or water borne disease (in 2 or more related cases) | <input type="checkbox"/> ☎ Lyssavirus not otherwise specified | <input type="checkbox"/> ☎ Typhoid |
| <input type="checkbox"/> ☎ Gastroenteritis involving 1 or more related cases in an institution or food handler | <input type="checkbox"/> ☎ Malaria | <input type="checkbox"/> Typhus (all forms) |
| <input type="checkbox"/> ☎ Gonococcal conjunctivitis | <input type="checkbox"/> ☎ Measles | <input type="checkbox"/> Varicella infection unspecified |
| <input type="checkbox"/> ☎ Haemolytic uraemic syndrome (HUS) | <input type="checkbox"/> ☎ Meningococcal infection | <input type="checkbox"/> ☎ Viral haemorrhagic fevers |
| | <input type="checkbox"/> Mumps | <input type="checkbox"/> - Crimean-Congo fever |
| | <input type="checkbox"/> ☎ Murray Valley Encephalitis | <input type="checkbox"/> - Ebola virus disease |
| | <input type="checkbox"/> Non-tuberculous mycobacterial disease | <input type="checkbox"/> - Lassa Fever |
| | | <input type="checkbox"/> - Marburg virus disease |
| | | <input type="checkbox"/> ☎ Yellow Fever |
| | | <input type="checkbox"/> Zoster (shingles) |

CASE DETAILS

Date of onset ____/____/____ Hospitalised Yes No Admission date ____/____/____ Date of death ____/____/____ (if applicable)

How was this case found? Clinical presentation / Contact tracing / Screening / Unknown

Clinical details _____

If the disease was vaccine-preventable please provide vaccination details:

Vaccination date	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Vaccine type (brand name)					

If the patient had a laboratory test please provide details or append the result:

Laboratory Westerns IMVS Sullivan Nicolaides Gribbles RDH GDH KDH ASH TCH Other

Specimen collected ____/____/____ Specimen Type (eg urine) _____

Diagnostic method (circle)

Serology Antigen detection Microscopy Histopathology Nucleic acid testing Culture Other Unknown

DOCTOR/CLINIC/HOSPITAL DETAILS

Name (or surgery/clinic stamp) _____ Telephone _____ Date of notification ____/____/____ Date received (CDC use only) ____/____/____

Address or Community (or surgery/clinic stamp) _____ Postcode _____ CDC January 2009

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