# Confidential – Notification of Infectious Disease

Diseases Marked ⓣ (whether presumptive or confirmed) require immediate notification by telephone or fax upon initial diagnosis.
All notifications must be sent within Five (5) days of diagnosis to:
DM&HO (District Medical & Health Officer), DPH (Director Public Health)

☑ Tick boxed where applicable
Please Print clearly

## 1. Sexually Transmitted Infections

**You must also complete sections 3 and 4**

☐ Chlamydia trachomatis infection
☐ Donovanosis
☐ Gonococcal Infection
☐ Syphilis ▶ ☐ Congential ☐ Early(<2Years) ☐ Late (<2 years)

**First two letters only:** Family Name __|__ First Name __|__ Postcodeof residence __|__|__|__

## 2. Other Infectious Diseases

**You must also complete sections 3 and 4**

☐ **Anthrax** ⓣ
☐ Arbovirus Infection
  ☐ **Australian arbo-encephalitis** ⓣ
  ☐ Barmah Forest virus
  ☐ Dengue Virus
  ☐ Flavivirus (other)
  ☐ **Japanese encephalitis** ⓣ
  ☐ Kunjin Virus
  ☐ Ross River Virus
☐ **Botulism** ⓣ
☐ Brucellosis
☐ Campylobacteriosis
☐ **Cholera** ⓣ
☐ Creutzfeldt-Jakob disease(CJD)
  ☐ Classical ☐ Variant
☐ Cryptosporidiosis

☐ **Diphtheria** ⓣ
☐ Food or water borne illness (2 or more related cases)
☐ Giardiasis
☐ **Haemolytic uraemic Syndrome(HUS)** ⓣ
☐ **Haemophilus influenza type b infection(Hib)** ⓣ
☐ Hepatitis A
☐ Hepatitis B
  ☐ Acute ☐ Chronic
☐ Hepatitis C
  ☐ Newly acquired < 2 years
  ☐ Chronic >2 Years
☐ Hepatitis D
☐ Hepatitis E
☐ Hepatitis Viral (not further specified)

☐ Influenza (Laboratory confirmed)
☐ **Leginellosis** ⓣ
☐ Leprosy
☐ Leptospirosis
☐ Listeriosis
☐ Lyssavirus
  ☐ Australian Bat Lyssavirus
☐ Malaria
☐ **Measles** ⓣ
☐ **Meningococcal Infection** ⓣ
☐ Mumps
☐ Mycobacterium Ulcerans
☐ **Paratyphoid** ⓣ
☐ Pertussis
☐ **Plague** ⓣ
☐ Pneumococcal infection (invasive)
☐ **Poliomyelitis** ⓣ

☐ Psittacosis (ornithosis)
☐ Q fever
☐ **Rabies** ⓣ
☐ Rubella
  ☐ Congenital subella syndrome
☐ Salmonellosis
☐ **Severe Acute Respiratory Syndrome (SARS)** ⓣ
☐ Shigellosis
☐ **Smallpox** ⓣ
☐ Tetanus
☐ Tuberculosis
☐ Tularaemis ⓣ
☐ Typhoid ⓣ
☐ Vero-toxin producing Esherichia coli (VTEC)
☐ Viral Haemorrhagic Fever ⓣ
☐ Yellow Fever ⓣ

Patient Surname _____ First Name (s) _____ Occupation _____

Patient Residential Address: _____

City/Suburb/Town _____ Post code of residence _____

## 3. Details for ALL Notifiable Diseases

Date of Birth (or Age if DOB unknown) _____
Date of Onset of illness _____
Risk factors _____

Sex (Gender)
☐ Female
☐ Male

Is the patient alive?
☐ Alive
☐ Deceased

Suspected mode of transmission _____

Clinical comments _____

Has laboratory confirmation been requested? ☐ No ☐ Yes, Pending at:
☐ Yes, confirmed at _____Laboratory

## 4. Notifier Details:

OFFICIAL Use Only:

| Name of Noatifying Doctor, PLaboratory or Hospital | |
|---|---|
| Address | |
| City/Suburb/Town | Post code |
| Telephone | E-mail ID: |
| Signature | Date |

Check: CC: