



# Infectious and Related Diseases Notification Form

Pursuant to the **WA Public Health Act 2016**, please notify your **Public Health Unit** of diseases marked with a  by telephone within 24 hours of diagnosis and all other diseases within 72 hours of diagnosis by post, telephone or fax. **For urgent  diseases after hours: Phone (08) 9328 0553.**

**Multi-resistant organisms (MRSA, CPO, VRE)** are notified by laboratories, and therefore notification by doctors or nurse practitioners is not necessary.

PATIENT DETAILS	NOTIFIABLE DISEASES <small>(tick box below) <input checked="" type="checkbox"/></small>
<b>Family name</b> _____ <b>Given name</b> _____ <b>Street address</b> _____ <b>Suburb/Town</b> _____ <b>Postcode</b> _____ <b>Tel. Home</b> _____ <b>Mobile</b> _____ <b>Date of birth</b> ____/____/____ <small>dd mm yyyy</small> <b>Sex at birth</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, specify _____ <b>Gender identity</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other, specify _____ <b>Country of birth</b> <input type="checkbox"/> Australia <input type="checkbox"/> Other, specify _____ <b>Preferred language</b> <input type="checkbox"/> English <input type="checkbox"/> Other, specify _____ <b>Occupation or name of school/childcare centre attended:</b> _____ <b>Is the patient of Aboriginal and/or Torres Strait Islander origin?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <small>(For persons of both Aboriginal and Torres Strait Islander origin, tick both 'yes' boxes.)</small>	<input type="checkbox"/> Acute post-streptococcal glomerulonephritis (APSGN) <input type="checkbox"/> Adverse event following immunisation – <b>use separate form</b> <input checked="" type="checkbox"/> Amoebic meningoencephalitis <input checked="" type="checkbox"/> Anthrax <input type="checkbox"/> Barmah Forest virus infection <input checked="" type="checkbox"/> Botulism <input type="checkbox"/> Brucellosis <input type="checkbox"/> <i>Campylobacter</i> infection Species: _____ <input type="checkbox"/> <i>Candida auris</i> <input type="checkbox"/> Infection <input type="checkbox"/> Colonisation <input type="checkbox"/> Chancroid <input type="checkbox"/> Chikungunya virus infection <input checked="" type="checkbox"/> Chlamydia <input type="checkbox"/> Lymphogranuloma venereum (serovar L1-3 detected) <input checked="" type="checkbox"/> Cholera <input type="checkbox"/> COVID-19 (human coronavirus of pandemic potential) <input type="checkbox"/> Creutzfeldt-Jakob disease (classical or variant) <input type="checkbox"/> Cryptosporidiosis <input type="checkbox"/> Dengue virus infection <input checked="" type="checkbox"/> Diphtheria <input type="checkbox"/> Donovanosis <input checked="" type="checkbox"/> Flavivirus infection <input type="checkbox"/> JE <input type="checkbox"/> MVE <input type="checkbox"/> West Nile/Kunjin <input type="checkbox"/> <input type="checkbox"/> Yellow fever <input type="checkbox"/> Zika <input type="checkbox"/> Other <input checked="" type="checkbox"/> Food or water-borne gastroenteritis (≥2 linked cases) <input type="checkbox"/> Gonococcal infection <input checked="" type="checkbox"/> Haemolytic uraemic syndrome (HUS) <input checked="" type="checkbox"/> <i>Haemophilus influenzae</i> type b (Hib) infection (invasive) <input checked="" type="checkbox"/> Hendra virus infection <input checked="" type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> newly acquired (<2 yrs) <input type="checkbox"/> Chronic/unspecified <input type="checkbox"/> Hepatitis C <input type="checkbox"/> newly acquired (<2 yrs) <input type="checkbox"/> Chronic/unspecified <input type="checkbox"/> Hepatitis (other) <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> HIV infection – <b>use separate form</b> <input type="checkbox"/> Influenza <input type="checkbox"/> A <input type="checkbox"/> B <input checked="" type="checkbox"/> Invasive Group A Streptococcal (iGAS) Disease <input checked="" type="checkbox"/> Legionellosis <input type="checkbox"/> Longbeachae <input type="checkbox"/> Pneumophila <input type="checkbox"/> Other <input type="checkbox"/> Leprosy <input checked="" type="checkbox"/> Leptospirosis <input checked="" type="checkbox"/> Listeriosis <input checked="" type="checkbox"/> Lyssavirus infection <input type="checkbox"/> Rabies <input type="checkbox"/> ABL <input type="checkbox"/> Other _____ <input checked="" type="checkbox"/> Malaria Species: _____ <input checked="" type="checkbox"/> Measles <input type="checkbox"/> Melioidosis <input checked="" type="checkbox"/> Meningococcal infection <input type="checkbox"/> Meningitis <input type="checkbox"/> Septicaemia <input type="checkbox"/> Other <input checked="" type="checkbox"/> Middle East Respiratory Syndrome coronavirus (MERS-CoV) <input checked="" type="checkbox"/> Monkeypox virus infection <input type="checkbox"/> Mumps <input checked="" type="checkbox"/> Paratyphoid fever <input type="checkbox"/> Pertussis <input checked="" type="checkbox"/> Plague <input checked="" type="checkbox"/> Pneumococcal infection (invasive) <input checked="" type="checkbox"/> Poliovirus infection <input checked="" type="checkbox"/> Psittacosis (ornithosis) <input type="checkbox"/> Q Fever <input type="checkbox"/> Respiratory Syncytial Virus (RSV) <input type="checkbox"/> Rheumatic fever/heart disease – <b>use separate form</b> <input type="checkbox"/> Rickettsial infection Species: _____ <input type="checkbox"/> Ross River virus infection <input type="checkbox"/> Rotavirus infection <input checked="" type="checkbox"/> Rubella <input type="checkbox"/> Non-congenital <input type="checkbox"/> Congenital <input checked="" type="checkbox"/> <i>Salmonella</i> infection Species: _____ <input checked="" type="checkbox"/> Severe Acute Respiratory Syndrome (SARS) <input type="checkbox"/> Shiga toxin-producing <i>E.coli</i> (STEC) infection <input checked="" type="checkbox"/> Shigellosis Species: _____ <input checked="" type="checkbox"/> Smallpox <input checked="" type="checkbox"/> Syphilis <input type="checkbox"/> 1° <input type="checkbox"/> 2° <input type="checkbox"/> Early latent (<2yrs) <input type="checkbox"/> Late latent <input type="checkbox"/> 3° <input type="checkbox"/> Congenital <input checked="" type="checkbox"/> Tetanus <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Tularaemia <input checked="" type="checkbox"/> Typhoid fever <input checked="" type="checkbox"/> Varicella-zoster virus <input type="checkbox"/> Chickenpox <input type="checkbox"/> Shingles <input type="checkbox"/> Unspecified <input checked="" type="checkbox"/> <i>Vibrio parahaemolyticus</i> infection <input checked="" type="checkbox"/> Viral haemorrhagic fever (Crimean-Congo, Ebola, Lassa, Marburg) <input checked="" type="checkbox"/> <i>Yersinia</i> infection
<b>DISEASE DETAILS</b> <b>How was the infection identified?</b> <input type="checkbox"/> Clinical presentation <input type="checkbox"/> Contact tracing <input type="checkbox"/> Screening <input type="checkbox"/> Other <b>Date of onset</b> ____/____/____ <b>Date of death</b> ____/____/____ <small>dd mm yyyy (if applicable) dd mm yyyy</small> <b>Place infection acquired</b> <input type="checkbox"/> WA <input type="checkbox"/> Interstate <input type="checkbox"/> Overseas <input type="checkbox"/> Unknown If acquired interstate/overseas, specify _____ <b>Was the patient hospitalised?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>How was diagnosis made?</b> <input type="checkbox"/> Lab <input type="checkbox"/> Result pending <input type="checkbox"/> Linked to lab-confirmed case <input type="checkbox"/> Clinical only Method: _____ Result: _____	
<b>FOLLOW-UP</b> <small>(tick one or more)</small> <input type="checkbox"/> Patient/carer aware of diagnosis and that it is a notifiable disease. <input type="checkbox"/> Risk to contacts discussed with patient. <input type="checkbox"/> Patient/carer aware Public Health Unit may contact them for information. <input type="checkbox"/> Other _____	
<b>CLINICAL COMMENTS</b> <small>(presentation, treatment)</small>  <b>Treatment commenced?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____	
<b>NOTIFIER DETAILS</b> <b>Name</b> _____ <b>Phone</b> _____ <b>Clinic/Hospital</b> _____ <b>Address</b> _____ _____ <b>Postcode</b> _____ <b>Signature</b> _____ <b>Date</b> ____/____/____ <small>dd mm yyyy</small>	



## ADDITIONAL NOTES:

Large empty rectangular area for additional notes.