



# Infectious and Related Diseases Notification Form

Pursuant to the WA Public Health Act 2016, please notify urgent 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. Post: Communicable Disease Control Directorate, PO Box 8172, Perth Business Centre WA 6849 Telephone: (08) 9222 0255 Fax: (08) 9222 0254 or for urgent 🚨 diseases after hours: Phone (08) 9328 0553. Multi-resistant organisms (MRSA, CPO, VRE) are notified by laboratories, therefore notification by doctors or nurse practitioners is not necessary.

PATIENT DETAILS	NOTIFIABLE DISEASES (tick box below) <input checked="" type="checkbox"/>
Family name _____	<input type="checkbox"/> Acute post-streptococcal glomerulonephritis (APSGN)
Given name _____	<input type="checkbox"/> Adverse event following immunisation – <b>use separate form</b>
Street address _____	<input type="checkbox"/> Amoebic meningoencephalitis
Suburb/Town _____ Postcode _____	<input type="checkbox"/> Anthrax
Tel. Home _____ Mobile _____	<input type="checkbox"/> Barmah Forest virus infection
Date of birth dd/mm/yyyy _____	<input type="checkbox"/> Botulism
Sex at birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Brucellosis
Gender identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> <i>Campylobacter</i> infection Species: _____
Country of birth <input type="checkbox"/> Australia <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> <i>Candida auris</i> <input type="checkbox"/> Infection <input type="checkbox"/> Colonisation
Preferred language <input type="checkbox"/> English <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Chancroid
Occupation or name of school/childcare centre attended: _____	<input type="checkbox"/> Chikungunya virus infection
Is the patient of Aboriginal and/or Torres Strait Islander origin? <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"/> Chlamydia <input type="checkbox"/> Lymphogranuloma venereum (serovar L1-3 detected)
	<input 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 type="checkbox"/> Diphtheria
	<input type="checkbox"/> Donovanosis
	<input type="checkbox"/> Flavivirus infection <input type="checkbox"/> JE <input type="checkbox"/> MVE <input type="checkbox"/> West Nile/Kunjin <input type="checkbox"/> Yellow fever <input type="checkbox"/> Zika <input type="checkbox"/> Other
	<input type="checkbox"/> Food or water-borne gastroenteritis (≥2 linked cases)
	<input type="checkbox"/> Gonococcal infection
	<input type="checkbox"/> Haemolytic uraemic syndrome (HUS)
	<input type="checkbox"/> <i>Haemophilus influenzae</i> type b (Hib) infection (invasive)
	<input type="checkbox"/> Hendra virus infection
	<input 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 type="checkbox"/> Invasive Group A Streptococcal (iGAS) Disease
	<input type="checkbox"/> Legionellosis <input type="checkbox"/> Longbeachae <input type="checkbox"/> Pneumophila <input type="checkbox"/> Other
	<input type="checkbox"/> Leprosy
	<input type="checkbox"/> Leptospirosis
	<input type="checkbox"/> Listeriosis
	<input type="checkbox"/> Lyssavirus infection <input type="checkbox"/> Rabies <input type="checkbox"/> ABL <input type="checkbox"/> Other _____
	<input type="checkbox"/> Malaria Species: _____
	<input type="checkbox"/> Measles
	<input type="checkbox"/> Melioidosis
	<input type="checkbox"/> Meningococcal infection <input type="checkbox"/> Meningitis <input type="checkbox"/> Septicaemia <input type="checkbox"/> Other
	<input type="checkbox"/> Middle East Respiratory Syndrome coronavirus (MERS-CoV)
	<input type="checkbox"/> Monkeypox virus infection
	<input type="checkbox"/> Mumps
	<input type="checkbox"/> Paratyphoid fever
	<input type="checkbox"/> Pertussis
	<input type="checkbox"/> Plague
	<input type="checkbox"/> Pneumococcal infection (invasive)
	<input type="checkbox"/> Poliovirus infection
	<input 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 type="checkbox"/> Rubella <input type="checkbox"/> Non-congenital <input type="checkbox"/> Congenital
	<input type="checkbox"/> <i>Salmonella</i> infection Species: _____
	<input type="checkbox"/> Severe Acute Respiratory Syndrome (SARS)
	<input type="checkbox"/> Shiga toxin-producing <i>E.coli</i> (STEC) infection
	<input type="checkbox"/> Shigellosis Species: _____
	<input type="checkbox"/> Smallpox
	<input 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 type="checkbox"/> Tetanus
	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Tularaemia
	<input type="checkbox"/> Typhoid fever
	<input type="checkbox"/> Varicella-zoster virus <input type="checkbox"/> Chickenpox <input type="checkbox"/> Shingles <input type="checkbox"/> Unspecified
	<input type="checkbox"/> <i>Vibrio parahaemolyticus</i> infection
	<input type="checkbox"/> Viral haemorrhagic fever (Crimean-Congo, Ebola, Lassa, Marburg)
	<input type="checkbox"/> <i>Yersinia</i> infection
DISEASE DETAILS	
How was the infection identified? <input type="checkbox"/> Clinical presentation <input type="checkbox"/> Contact tracing <input type="checkbox"/> Screening <input type="checkbox"/> Other	
Date of onset dd/mm/yyyy _____ Date of death (if applicable) dd/mm/yyyy _____	
Place infection acquired <input type="checkbox"/> WA <input type="checkbox"/> Interstate <input type="checkbox"/> Overseas <input type="checkbox"/> Unknown If acquired interstate/overseas, specify _____	
Was the patient hospitalised? <input type="checkbox"/> No <input type="checkbox"/> Yes	
How was diagnosis made? <input type="checkbox"/> Lab <input type="checkbox"/> Result pending <input type="checkbox"/> Linked to lab-confirmed case <input type="checkbox"/> Clinical only Method: _____ Result: _____	
FOLLOW-UP (tick one or more)	
<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 _____	
CLINICAL COMMENTS (presentation, treatment)	
Treatment commenced? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify _____	
NOTIFIER DETAILS	
Name _____ Phone _____	
Clinic/Hospital _____	
Address _____ Postcode _____	
Signature _____ Date dd/mm/yyyy _____	



## ADDITIONAL NOTES:

Large empty rectangular area for additional notes.