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 or (08) 9328 0553 (for urgent diseases marked with a ☑ after hours) Fax: (08) 9222 0254. Multi-resistant organisms (MRSA, CRE, VRE) are notified by laboratories, and therefore notification by doctors or nurse practitioners is not necessary.

PATIENT DETAILS

Family name ________________________________
Given name ________________________________
Street address ________________________________
Suburb/Town __________________ Postcode __________
Tel. Home __________ Mobile __________
Date of birth dd/mm/yyyy
Sex at birth ☐ Male ☐ Female ☐ Other, specify ____________________________
Gender identity ☐ Male ☐ Female ☐ Non-Binary ☐ Other, specify ____________________________
Country of birth ☐ Australia ☐ Other, specify ____________________________
Preferred language ☐ English ☐ Other, specify ____________________________
Occupation or name of school/childcare centre attended:

Is the patient 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 ☐ Other

Date of onset dd/mm/yyyy
Date of death 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 (presentation, treatment)

Treatment commenced?
☐ No ☑ Yes, specify ____________________________

NOTIFIER DETAILS

Name ________________________________ Phone ________________________________
Clinic/Hospital ________________________________
Address _________________________________________________________________
__________________________________________________________ Postcode ______
Signature __________________________________ Date dd/mm/yyyy

☐ Tick this box if you require more forms and pre-paid envelopes (or print from ww2.health.wa.gov.au/Articles_N/R/Notification-of-infectious-diseases-and-related-conditions). Jan 2022