

# Confidential and Routine Conditions Notifiable by Medical Practitioners in Victoria



Department  
of Health

The following conditions require written notification to the Department of Health on initial diagnosis within five days to:

**Department of Health, Reply Paid 65937, Melbourne VIC 8060 or fax 1300 651 170.**

Please ensure the case (1) has been informed of their diagnosis, (2) has been advised that this information is being provided to the department, and (3) has been informed that the department may contact them for further information about their illness. Commonwealth and State privacy legislation does not negate the responsibility to notify the specified conditions or to provide the information requested on this form.

## Please indicate the condition you are notifying

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Brucellosis*                    | <input type="checkbox"/> Hepatitis E   | <input type="checkbox"/> Rubella*  |
| <input type="checkbox"/> Chikungunya virus infection*    | <input type="checkbox"/> Kunjin virus infection                                  | <input type="checkbox"/> Congenital rubella*   |
| <input type="checkbox"/> Creutzfeldt-Jakob disease (CJD) | <input type="checkbox"/> Leprosy   | <input type="checkbox"/> Salmonellosis   |
| <input type="checkbox"/> Variant CJD                     | <input type="checkbox"/> Lyssavirus—Australian bat lyssavirus                    | <input type="checkbox"/> Shiga toxin and verotoxin producing <i>Escherichia coli</i> (STEC/VTEC) |
| <input type="checkbox"/> Cryptosporidiosis               | <input type="checkbox"/> Lyssavirus—other, specify _____                         | <input type="checkbox"/> Shigellosis*  |
| <input type="checkbox"/> Dengue virus infection*         | <input type="checkbox"/> Malaria*  | <input type="checkbox"/> Tetanus   |
| <input type="checkbox"/> Hepatitis B—Newly acquired*     | <input type="checkbox"/> Mumps*  | <input type="checkbox"/> Tuberculosis*   |
| <input type="checkbox"/> Hepatitis B—Unspecified*        | <input type="checkbox"/> <i>Mycobacterium ulcerans</i> infection (Buruli ulcer)* | <input type="checkbox"/> Varicella zoster—Chickenpox   |
| <input type="checkbox"/> Hepatitis C—Newly acquired*     | <input type="checkbox"/> Pertussis   | <input type="checkbox"/> Varicella zoster—Shingles   |
| <input type="checkbox"/> Hepatitis C—Unspecified*        | <input type="checkbox"/> Pneumococcal infection (invasive)*                      | <input type="checkbox"/> West Nile/Kunjin virus infection  |
| <input type="checkbox"/> Hepatitis D                     | <input type="checkbox"/> Q fever*  |  |

\*Enhanced data are collected for these conditions. We encourage the use of enhanced surveillance forms, accessible via the 'Form' links at [www.health.vic.gov.au/notify](http://www.health.vic.gov.au/notify).

## Case details—please answer all questions

<b>Last name</b> <input type="text"/>		<b>Interpreter required</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, language > _____	
<b>First name(s)</b> <input type="text"/>		<b>Works in a high risk occupation</b> <input type="checkbox"/> Child care worker <input type="checkbox"/> Health care worker <input type="checkbox"/> Commercial food handler <input type="checkbox"/> Other, specify below _____	
<b>Date of birth</b> <input type="text"/>	<b>Medicare or other healthcare identifier</b> <input type="text"/>	<b>Occupation and/or school and/or child care attended</b> <input type="text"/>	
<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other, specify > _____		<b>Has the case recently travelled interstate or overseas</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, specify when/where > _____	
<b>Residential address</b> <input type="text"/>		<b>Alive/deceased</b> <b>...date of death</b> <input type="checkbox"/> Alive <input type="checkbox"/> Died due to this condition > _____ <input type="checkbox"/> Died due to other causes > _____	
<b>City</b> <input type="text"/>	<b>Postcode</b> <input type="text"/>	<b>Date of onset of illness</b> <input type="text"/>	
<b>Tel home</b> <input type="text"/>	<b>Tel mobile</b> <input type="text"/>	<b>Has laboratory testing been requested</b> <input type="checkbox"/> No <input type="checkbox"/> Confirmed, specify lab > _____ <input type="checkbox"/> Pending, specify lab > _____	
<b>Parent/guardian/next of kin name</b> <input type="text"/>		<b>Clinical comments</b> – include risk factors, mode of transmission, history of illness, symptoms etc. <input type="text"/> <input type="text"/> <input type="text"/>	
<b>Is the case of Aboriginal or Torres Strait Islander origin</b> <input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Unknown <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander			
<b>Country of birth ...country</b> <input type="checkbox"/> Australia <input type="checkbox"/> Overseas > _____		<b>...year arrived in Australia</b> <input type="text"/>	

## Notifying doctor/hospital/laboratory details

<b>Doctor/hospital/laboratory name</b> <input type="text"/>		<b>Medicare provider no.</b> <input type="text"/>	<b>Department use only</b>
<b>Address</b> <input type="text"/>			
<b>City</b> <input type="text"/>	<b>Postcode</b> <input type="text"/>		
<b>Telephone</b> <input type="text"/>	<b>Fax</b> <input type="text"/>	<b>Date</b> <input type="text"/>	