Confidential and Routine
Conditions Notifiable by Medical Practitioners in Victoria

VICTORIA State Government | 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

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

*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.

Case details—please answer all questions

Last name

First name(s)

Date of birth

Medicare or other healthcare identifier

Sex
- ☐ Male
- ☐ Female
- ☐ Other, specify > _____

Residential address

City

Postcode

Tel home

Tel mobile

Parent/guardian/next of kin name

Is the case of Aboriginal or Torres Strait Islander origin
- ☐ No
- ☐ Unknown
- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander

Country of birth ...country
- ☐ Australia
- ☐ Overseas > _____

...year arrived in Australia

Interpreter required
- ☐ No
- ☐ Yes, language > _____

Works in a high risk occupation
- ☐ Child care worker
- ☐ Commercial food handler
- ☐ Health care worker
- ☐ Other, specify below

Occupation and/or school and/or child care attended

Has the case recently travelled interstate or overseas
- ☐ No
- ☐ Yes, specify when/where > _____

Alive/deceased
- ☐ Alive
- ☐ Died due to this condition >
- ☐ Died due to other causes >

...date of death

Date of onset of illness

Has laboratory testing been requested
- ☐ No
- ☐ Confirmed, specify lab > _____
- ☐ Pending, specify lab > _____

Clinical comments – include risk factors, mode of transmission, history of illness, symptoms etc.

Notifying doctor/hospital/laboratory details

Doctor/hospital/laboratory name

Medicare provider no.

Address

City

Postcode

Telephone

Fax

Date

Department use only