

Confidential and Routine Notification of Zika Virus Disease by Medical Practitioners



Health and Human Services

Group B arbovirus infections require written notification to the Department of Health & Human Services upon initial diagnosis within five days to:

Department of Health & Human Services, Reply Paid 65937, Melbourne VIC 8060 or fax 1300 651170.

Please ensure the case (1) has been informed of their diagnosis, (2) has been advised that this information is being provided to the department (as required by the *Health Records Act 2001*), 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 nor to provide the information requested on this form.

Case details—please answer all questions

Last name

First name(s)

Date of birth

Sex

- Male Other, specify _____
 Female

Residential address

City

Postcode

Tel home

Tel mobile

Parent/guardian/next of kin name and contact number

Is the case of Aboriginal or Torres Strait Islander origin

- No
 Aboriginal
 Torres Strait Islander
 Both Aboriginal and Torres Strait Islander
 Unknown

Country of birth ...country

...year arrived in Australia

Australia

Overseas > _____

Interpreter required ...language

No

Yes, language > _____

Occupation and/or school and/or child care attended

Alive/deceased

Alive

Died due to Zika virus >

Died due to other causes > _____

...date of death

Clinical summary

Date of onset of illness

If female, is the case pregnant

No

Yes, specify _____ /40 weeks on date _____

Symptoms

- Asymptomatic Guillain-Barré Other, specify below
 Arthralgia syndrome
 Conjunctivitis Myalgia
 Fever Rash
 Headache _____

Case required hospitalisation for this illness

No

Yes, specify hospital _____

Admitted date

Discharged date

Has laboratory testing been requested

No

Confirmed, specify lab > _____

Pending, specify lab > _____

What other diagnostic tests have you requested for this case for this illness

Chikungunya virus

Other, specify below _____

Dengue virus

Malaria

Has the case previously tested positive for any mosquito borne disease

No

Unknown

Yes, specify disease(s) and year(s) _____

Has the case been vaccinated for Japanese Encephalitis or Yellow Fever

No

Unknown

Yes, specify vaccine name below _____

... Date of vaccination

Form continues over page

Notifying doctor/hospital/laboratory details

Doctor/hospital/laboratory name

Medicare provider no.

Department use only

Address

City

Postcode

Telephone

Fax

Date

Please identify the case on every page

Last name

First name

Date of birth

Risk summary

In order to determine the risk of acquiring infection, as well as the risk of transmitting infection, it is important to have a clear travel history. Did the case travel interstate or overseas at any time from 14 days before until one week after symptom onset

If the case was asymptomatic, please specify all recent interstate or overseas travel

- No
- Unknown
- Yes, specify travel history below

Where (country or state)

from date

to date

Where (country or state)	from date	to date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Did the case seek travel health advice prior to travelling

- No
- Unknown
- Yes, from a GP
- Yes, from a travel health clinic
- Yes, from the Smart Traveller website

Has the case had sexual contact with a confirmed Zika case or a man who has travelled to a Zika affected country in the past 8 weeks

- No
- Unknown
- Yes

Did the case travel with a pregnant woman or has the case had recent sexual contact with a pregnant woman

- No
- Unknown
- Yes

Clinical comments include risk factors, mode of transmission (if any) etcetera