

Confidential and Routine Notification of Tuberculosis by Medical Practitioners



Health
and Human
Services

Tuberculosis requires 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 and/or the Victorian Tuberculosis Program 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

How many people live at the specified residential address

Total number adults and children

Number of children

Is the case of Aboriginal or Torres Strait Islander origin

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

Country of birth ...country

...year arrived in Australia

Australia

Overseas > _____

...if born overseas, is the case currently on a TB Health Undertaking

- No
 Unknown
 Yes, is currently on a TB Health Undertaking

Interpreter required ...language

No

Yes, language > _____

Occupation and/or school and/or child care attended

Clinical summary

Alive/deceased

- Alive Died due to Tuberculosis >
 Died due to other causes > _____

...date of death

...specify other cause of death (if known)

Date of onset of illness

Symptoms

- Fever Cough, specify > ...duration of cough
 Sweats Sputum
 Weight loss Haemoptysis
 Other, specify below

When did the case first present to a health professional for screening or with symptoms of TB (partial date OK)

Has the case been tested for HIV infection

- Yes, positive No
 Yes, negative Unknown
 Yes, result unknown Refused testing
 Testing pending

Is this a new case or a relapse

- New case Relapse following full treatment in Australia
 Relapse following partial treatment in Australia
 Relapse following full treatment overseas
 Relapse following partial treatment overseas

Does the case have any of the following conditions/risks

- Alcohol and/or other drugs Mental health—Cognitive impairment
 Chronic liver disease Mental health—Psychiatric illness
 Diabetes Smoking

Is the case a current in-patient in hospital

No

Yes, estimated discharge date > _____

Hospital URN

Form continues over page

Notifying doctor/hospital/laboratory details

Doctor/hospital/laboratory name

Medicare provider no.

Treating unit

Address

Department use only

City

Postcode

Telephone

Fax

Date

Please identify the case on every page

Last name

First name

Date of birth

Risk factors for Tuberculosis (tick all that apply)

- Household member or close contact with TB
- Ever resided in a correctional facility
- Ever resided in an aged care facility
- Ever employed in an institution (correctional facility, aged care facility, homeless shelter)
- Ever employed in the Australian health industry (including health laboratories)
- Ever employed in health industry overseas (including health laboratories)
- Currently working or worked in last 12 months in the Australian health industry (including health laboratories)
- Currently working or worked in last 12 months in the health industry overseas (including health laboratories)
- Ever homeless
- Past travel to or residence (3 months or more) in a high-risk country as defined by Department of Immigration and Citizenship
- Chest X-ray suggestive of old untreated TB
- Currently receiving immunosuppressive therapy (for example, $\geq 1\text{mg/kg}$ or $>50\text{mg}$ prednisolone daily or equivalent)
- Australian-born child (aged less than 15 years) with one or more parents born in a high-risk country
- None of the above risk factors
- Not assessed

Medical summary – testing and site

Specimen	Specimen date	Test and result	Positive Negative Not done Unknown	Test date
Sputum specimen		Microscopy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Culture	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Nucleic acid testing/PCR	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Bronchial washings		Microscopy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Culture	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Nucleic acid testing/PCR	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Histology	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Other specimen, specify		Microscopy	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Culture	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Nucleic acid testing/PCR	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
		Histology	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Date of chest X-ray / CT

Radiology facility name

Chest X-ray / CT results

- Normal Not done Unknown
- Abnormal, if abnormal, please provide comments below

Site of disease

- Pulmonary only
- Pulmonary plus other site(s), specify other site(s) >
- Extra-pulmonary only, specify site(s) >
- Bone joint
- Genito/urinary
- Lymph nodes
- Meningeal
- Miliary
- Peritoneal
- Pleural
- Other, specify other site(s)

Treatment details

Anti-tuberculosis treatment commencement date

What is the current treatment regimen

- Isoniazid
- Rifampicin
- Pyrazinamide
- Ethambutol
- Other, specify

Please advise your patient that a Clinical Nurse Consultant from the Victorian Tuberculosis Program will be contacting them following discharge. Arrangements will then be made for contact screening if required. For further information please contact the Victorian Tuberculosis Program on (03) 9342 9478.