

Chikungunya virus requires written notification to the Department of Health within five days of initial diagnosis 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 (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 or to provide the information requested on this form.

Case details—please answer all questions

Last name

First name(s)

Date of birth Medicare or other healthcare identifier

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
 Unknown Torres Strait Islander
 Both Aboriginal and Torres Strait Islander

Country of birth ...country ...year arrived in Australia
 Australia
 Overseas > _____

Interpreter required
 No
 Yes, language > _____

Occupation and/or school and/or child care attended

Alive/deceased ...date of death
 Alive Died due to Chikungunya > _____
 Died due to other causes > _____

If female, is the case pregnant
 No
 Yes, number of weeks gestation > _____ / 40

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

Clinical summary

Date of onset of illness

Symptoms
 Arthralgia Myalgia
 Chills Nausea
 Conjunctivitis Rash
 Fever Retro orbital pain
 Headache Vomiting
 Lethargy Other, specify below
 Loss of appetite _____

Did the case require hospitalisation for this illness
 No
 Yes, specify hospital > _____
 date admitted date discharged

Has the case previously tested positive for any mosquito borne disease
 No
 Yes, specify disease and year > _____

Risk history

In the 14 days before the onset of symptoms, did the case travel overseas or interstate (if more than two locations were visited, please provide further details in the Clinical comments section)

Location 1 (city and country OR city and state)
 from date to date

Location 2 (city and country OR city and state)
 from date to date

Clinical comments Include risk factors, further travel locations, etcetera

Notifying doctor/hospital/laboratory details

| | | |
|---------------------------------|-----------------------|---------------------|
| Doctor/hospital/laboratory name | Medicare provider no. | Department use only |
| Address | | |
| City | Postcode | |
| Telephone | Fax | |
| | | Date |