

Pneumococcal Infection requires written notification to the Department of Health upon 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 (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
 Female
 Other, specify >

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
 No
 Yes, language >

Occupation and/or school and/or child care attended

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

Clinical summary

Date of onset of illness

Clinical manifestation (tick all that apply)
 Pneumonia, confirmed by X-ray > Yes
 No
 Unknown
 Meningitis (with supportive neurological clinical features)
 Bacteraemia (septicaemia)
 Other, specify >
 Unknown

Has the case previously been diagnosed with IPD (prior to the current infection)
 No
 Unknown
 Yes, specify date >

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

Pneumococcal vaccination history

Has the case been immunised with a pneumococcal vaccine
 No
 Unknown
 Yes, specify below

Vaccine	Information source	Date of vaccination
<input type="checkbox"/> Prevenar 7	<input type="checkbox"/> Written record	
<input type="checkbox"/> Prevenar 13	<input type="checkbox"/> Parent/self recall	
<input type="checkbox"/> Pneumovax 23		
<input type="checkbox"/> Unknown		
<input type="checkbox"/> Prevenar 7	<input type="checkbox"/> Written record	
<input type="checkbox"/> Prevenar 13	<input type="checkbox"/> Parent/self recall	
<input type="checkbox"/> Pneumovax 23		
<input type="checkbox"/> Unknown		
<input type="checkbox"/> Prevenar 7	<input type="checkbox"/> Written record	
<input type="checkbox"/> Prevenar 13	<input type="checkbox"/> Parent/self recall	
<input type="checkbox"/> Pneumovax 23		
<input type="checkbox"/> Unknown		

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 factor details—please answer all questions

Smoking risk

- Current smoker, specify cigarettes per day > _____
- Ex smoker (>100 cigarettes in lifetime)
- Never smoked
- Unknown

Household smoking risk

- Smoker in household
- No smoking risk
- Unknown

Does the case have an immunocompromising condition

- No
- Unknown
- Immunosuppressive therapy (incl. high dose steroids & radiotherapy)
- Anatomical or functional asplenia*
- HIV infection
- Nephrotic syndrome
- Organ transplantation or haematopoietic stem cell transplant
- Multiple myeloma
- Other cancer, specify below
- Other (incl. chronic pancytopenia, IgA deficiency, active SLE, other autoimmune diseases), specify below

*** For patients with anatomical or functional asplenia, please consider:**

- **Pneumococcal vaccination (refer to the current recommendations in the Australian Immunisation Handbook, or online at www.immunise.health.gov.au).**
- **Registering the patient with Spleen Australia (www.spleen.org.au) for advice on optional immunisation administration, use of antibiotics, and education on staying healthy.**

Does the case have a chronic disease

- No
- Unknown
- Cardiac disease (but not uncomplicated hypertension)
- Chronic renal failure with reduced function
- Chronic liver disease with reduced function
- Chronic airway limitations (e.g. due to bronchiectasis, emphysema, scarring requiring hospitalisation or chronic treatment)
- Diabetes (type 1 or 2)
- Excessive alcohol use
- CSF leak
- Severe asthma
- Chronic or recurrent infections (incl. pancreatitis, chronic otitis media)
- Other chronic conditions impairing physical functioning (e.g. cerebral palsy, neurological deficit, malnutrition), specify below

For children UNDER 5 years of age

Congenital or chromosomal abnormality

- No
- Yes, specify > _____

Gestational age in weeks

Did the child attend grouped care outside the home within 4 weeks of onset for greater than 4 hours

- No
- Unknown
- Yes, specify hours per week > _____

Clinical comments

Clinical comments / History of illness include any relevant comments (e.g. risk factors, mode of transmission, etc.)

Data collection ends here. Thank you.