

REPORT OF NOTIFIABLE DISEASE OR RELATED DEATH



Government of South Australia
Department of Health

CONFIDENTIAL

Public & Environmental Health Act – 1987

DISEASE TO NOTIFY

Please print clearly and tick all applicable boxes

Disease: Influenza H1N1 2009 (Swine)

Please specify symptoms:

- | | | |
|---|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Fever | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> SOB | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Myalgia/Arthralgia | <input type="checkbox"/> Rigors | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Other..... | | |

Risk factors - complications: Yes No

- | | |
|--|--|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Metabolic diseases | <input type="checkbox"/> Cardiac disease |
| <input type="checkbox"/> Renal failure | <input type="checkbox"/> Immunosuppression |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Morbid obesity |
| <input type="checkbox"/> Respiratory disease (asthma/COAD) | <input type="checkbox"/> Haemoglobinopathies |
| <input type="checkbox"/> Other..... | |

Hospitalised? Yes No

If yes, date of admission/...../.....

Date of discharge/...../.....

Admitted to ICU? Yes No

Was the case ventilated? Yes No

Date of death (if applicable):/...../.....

Antivirals administered? Yes No

Date Commenced:/...../.....

Influenza vaccination status:

Vaccinated this season? Yes No Unsure

Ever vaccinated? Yes No Unsure

Does the patient know the test result?

Yes No

Please inform the patient that you have notified the Department of Health.

CASE DETAILS

Please print clearly and tick all applicable boxes

Last name:

Given name:

Address:

Town/Suburb:Postcode

Telephone: H.....

M.....

Date of birth: / / Sex: M F

Date of onset: / /

Is the case of Aboriginal or Torres Strait Islander origin?

- No (not Aboriginal or TSI) Yes, Aboriginal
 Both Aboriginal & Torres Strait Islander Yes, Torres Strait Islander

What is the case's occupation?

Please specify

Doctor details

Name: Dr

Address:

Telephone

Signature: Date: / /

Laboratory: testdate:

Clinical comments (include any *others ill*, identified by you or the case):

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Please fax the completed form to: (08) 8226 7187

OR Telephone (08) 8226 7177

OR post to : CDC Branch, Reply Paid 6 ,PO Box 6, Rundle Mall, Adelaide SA 5000