Case name: ..... DOB ...../...../..... Notification ID: .....
First name Surname

Arboviral Disease Case Report Form

Queensland Government

Public Health Unit Outbreak ID: .....

Completed by: ..... Date sent to NOCS: ...../...../.....

Telephone: ..... Fax: .....

List of notifiable arboviral conditions

Arbovirus infection: other, not specified

Alphavirus infection: Ross River virus, Barmah Forest virus, Chikungunya (separate form available), Getah, Sindbis

Bunyavirus infection: Gan Gan, Mapputta, Termeil, Trubanaman etc

Flavivirus infection: Unspecified, Yellow fever, Murray Valley encephalitis, Japanese encephalitis, Alfuy, Edge Hill, Kokobera, West Nile, Kunjin, Dengue (separate form available)

NOTIFICATION of .....

Date PHU notified: ...../...../..... Date initial response: ...../...../..... Notifier: .....

Telephone: ..... Fax: ..... Email: .....

Treating Dr: .....

Telephone: ..... Fax: ..... Email: .....

CASE DETAILS: **UR No:** .....

Name: .....
First name Surname

Date of birth: ...../...../..... Age: .....Years ..... Months Sex: ☐ Male ☐ Female .....

Name of parent/carer: .....

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Non-Indigenous ☐ Unknown

English preferred language: ☐ Yes ☐ No – specify ..... Ethnicity – specify .....

Permanent address: .....

..... Postcode: .....

Home telephone: ..... Mob: ..... Email: .....

Occupation: ..... Work telephone: .....

Temporary address in Queensland (if different from permanent address) : .....

..... Postcode: .....

Telephone: ..... Mob: ..... Email: .....

General Practitioner: Dr .....

Address: ..... Postcode: .....

Telephone: ..... Fax: ..... Email: .....

CLINICAL DETAILS:

Onset of symptom ...../...../..... Date of first consultation ...../...../.....

Signs and symptoms:

☐ Fever>38°C ..... °C ☐ Chills ☐ Headache ☐ Nausea ☐ Vomiting ☐ Retro-orbital pain

☐ Myalgia ☐ Backache ☐ Joint pain ☐ Bradycardia ☐ Lymphadenopathy .....

☐ Maculopapular rash (non pruritic) ☐ Other rash – specify: .....

Case name: ..... DOB ...../...../..... Notification ID: .....
First name Surname

☐ Weakness in lower limbs ☐ Confusion ☐ Retinitis ☐ Respiratory failure ☐ Shock

☐ Hepatitis ☐ Jaundice ☐ Liver failure ☐ Renal abnormality or failure

☐ Other .....

Hemorrhagic: ☐ Epistaxis ☐ Gingival bleeding ☐ Haematemesis ☐ Melena

☐ Other – specify .....

Neuroinvasive: ☐ Abnormal reflexes ☐ Paresis ☐ Disorientation ☐ Convulsion ☐ Coma

☐ Paralysis – specify history .....

☐ Other – specify .....

☐ Aseptic meningitis ☐ Encephalitis ☐ Acute flaccid paralysis ☐ Other .....

Treatment commenced: ☐ Yes ☐ No Date: ...../...../.....

Details: .....

Hospitalised: ☐ Yes ☐ No ☐ Unknown Hospital: ..... Date: ...../...../..... to ...../...../.....

Complications: ☐ Yes – specify ..... ☐ No ☐ Unknown

LABORATORY: Laboratory: ..... First collection date: ...../...../.....

Lab No:	**Specify Specimen**	**Date specimen collected**	**Positive**	**Negative**	**Not tested**	**Date result reported**
..... virus specific IgM	.....	...../...../.....	☐	☐	☐	...../...../.....
IgG (fourfold or greater rise) results...	.....	...../...../.....	☐	☐	☐	...../...../.....
Isolation of ..... virus	.....	...../...../.....	☐	☐	☐	...../...../.....
Detection of ..... virus by PCR	.....	...../...../.....	☐	☐	☐	...../...../.....
Detection of ..... virus in tissue/liver histopathology/immunohistochemistry (Yellow fever)	.....	...../...../.....	☐	☐	☐	...../...../.....

☐ Elevated Liver enzymes ☐ Abnormalities in clotting factor ☐ Albuminuria ☐ Other.....

VACCINATION DETAILS:

Dose	**Date**	**Type**	**Comments**
1	...../...../.....	.....	.....
2	...../...../.....	.....	.....
3	...../...../.....	.....	.....

Vaccination status: ☐ Age-appropriate ☐ Incomplete ☐ Not vaccinated ☐ Unknown

Source of vaccination history: ☐ ACIR/VIVAS/Health Record ☐ Self/parental recall ☐ Not validated

Case name: ..... DOB ...../...../..... Notification ID: .....
First name Surname

NOTIFICATION DECISION: ☐ Confirmed case of .....

☐ Invalidated case – specify .....

Outcome: ☐ Survived ☐ Died Date of death: ...../...../..... ☐ Died of condition ☐ Unknown

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EXPOSURE PERIOD: ...../...../..... to ...../...../.....
(Onset date ± .....days) (Onset date ± .....days)

Travel history:

Was the case interstate or overseas 10 days prior to fever onset? ☐ Yes ☐ No ☐ Unknown

Date of travel: ...../...../..... to ...../...../..... Places visited: .....

During this time was there contact with confirmed/suspected case(s)? ☐ Yes ☐ No ☐ Unknown

Name / NID: ..... Telephone: ..... Contact type: .....

Name / NID: ..... Telephone: ..... Contact type: .....

PLACE ACQUIRED:

☐ Queensland ☐ Other Australian state/territory – specify .....

☐ Unknown ☐ Other country – specify .....

Comments: .....

Home address: ..... ☐ Screens ☐ Air con ☐ Mozzies

Work address: ..... ☐ Screens ☐ Air con ☐ Mozzies

Other significant address:

1. ..... ☐ Screens ☐ Air con ☐ Mozzies
2. ..... ☐ Screens ☐ Air con ☐ Mozzies

VIRAEMIC PERIOD: ...../...../..... to ...../...../.....
(Onset date ± .....days) (Onset date ± .....days)

Home address: ..... ☐ Screens ☐ Air con ☐ Mozzies

Other main address:

1. ..... ☐ Screens ☐ Air con ☐ Mozzies
2. ..... ☐ Screens ☐ Air con ☐ Mozzies

Work during this period: ☐ Yes ☐ No Dates: .....

If Yes, name of work place: ..... Address: .....

CONTACTS:

Name	Age	Recent febrile like illness	Intervention
.....	.....	☐ Yes ☐ No	.....
.....	.....	☐ Yes ☐ No	.....
.....	.....	☐ Yes ☐ No	.....
.....	.....	☐ Yes ☐ No	.....
.....	.....	☐ Yes ☐ No	.....

Precautions discussed: ☐ Yes ☐ No Fact sheet sent: ☐ Yes ☐ No Date: ...../...../.....

Contact management required: ☐ Yes ☐ No

COMMENTS: