

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

First name

Surname



# Case Report Form

Public Health Unit Outbreak ID: .....  
Completed by: ..... Date sent to NOCS: ...../...../.....  
Telephone: ..... Fax: .....

## NOTIFICATION:

Date PHU notified: ...../...../..... Date initial response: ...../...../.....  
Notifier: ..... Organisation: .....  
Telephone: ..... Fax: ..... Email: .....  
Treating Dr: .....  
Telephone: ..... Fax: ..... Email: .....

## CASE DETAILS:

UR No: .....

Name: .....  
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 tel: ..... 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 symptoms ...../...../..... Date of first consultation ...../...../..... Details: .....  
Hospitalised:  Yes  No  Unknown Hospital: ..... Date: ...../...../..... to ...../...../.....  
Complications:  Yes – specify .....  No  Unknown  
Outcome:  Survived  Died Date of death: ...../...../.....  Died of condition  Unknown

## LABORATORY:

Laboratory: ..... Collection date: ...../...../.....

Type of specimen: .....  
Organism identified: .....  
ID a ethod:  Serology  PCR  Other .....

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

**VACCINATION DETAILS:**

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

Vaccination status:  Age-appropriate  Incomplete  Not vaccinated  Unknown  
Source of vaccination history:  ACIR/VIVAS/Health Record  Self/parental recall  Unknown

**EXPOSURE PERIOD:**

Date: ...../...../..... to Date: ...../...../.....  
(Onset date ± ..... days) (Onset\_date + ..... days)

Did case attend any of the following during their exposure period?

- Childcare – *specify* ..... Telephone: ..... Dates attended: .....
- Preschool/school – *specify* ..... Telephone: ..... Dates attended: .....
- Educational/residential facility – *specify* ..... Telephone: ..... Dates attended: .....
- Hosp/healthcare facility – *specify* ..... Telephone: ..... Dates attended: .....
- Other risk setting(s) – *specify* ..... Telephone: ..... Dates attended: .....

**Travel History (if relevant):**

Was the case interstate or overseas in exposure period?  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* .....

**INFECTIOUS PERIOD:**

Date: ...../...../..... to Date: ...../...../.....  
(Onset date ± ..... days) (Onset date ± ..... days)

Appropriate treatment commenced:  Yes  No  Unknown Date: ...../...../.....

Details:

Did case attend any of the following during their infectious period?

- Childcare – *specify* ..... Telephone: ..... Dates attended: .....
- Preschool/school – *specify* ..... Telephone: ..... Dates attended: .....
- Educational/residential facility – *specify* ..... Telephone: ..... Dates attended: .....
- Hosp/healthcare facility – *specify* ..... Telephone: ..... Dates attended: .....
- Other risk setting(s) – *specify* ..... Telephone: ..... Dates attended: .....

Was the case excluded from child care/ school/ other high risk setting:  Yes  No  Unknown

**NOTIFICATION DECISION:**  Confirmed – ..... case  Probable – ..... case

**COMMENTS:**

Case name: .....  
*First name* *Surname*

DOB ...../...../.....

Notification ID: .....

**CONTACT MANAGEMENT**

**(PHU use only)**

**Mode of transmission**

- Droplet     
  Air borne     
  Blood borne     
  Food borne     
  Faecal-oral     
  Vector borne     
  Not identified

Name	Type of contact	Age/DOB	Phone	Intervention	Comments