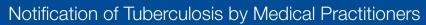
## Confidential and Routine





Tuberculosis 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 and/or the Victorian Tuberculosis Program 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		Occupation and/or school and/or childcare attended			
First name(s)		Clinical summary			
Date of birth URN		Alive Date of death			
		☐ Died due to Tuberculosis > ☐ Died due to other/unknown causes > ☐ Died due to othe			
Sex Medicare  Male Yes Female No Other, specify >		Date of symptoms onset			
Residential address		Symptoms  Fever Cough, specify duration > ,			
City	Postcode	Haemoptysis Weight loss Sputum Other, specify > Sweats			
Tel home	Tel mobile	When was the first presentation to a health professional (e.g., GP) for screening or with symptoms of TB (partial date OK)			
Parent/guardian/next of kin name an	d contact number	Has testing for HIV been offered/provided  Yes, positive No Yes, negative Unknown			
How many people live at the specified residential address  Total number adults and children  Number of children		Yes, result unknown Preferred not to test Testing pending			
Is this person of Aboriginal or Torres  No Unknown Aboriginal Torres Strait Islander Both Aboriginal and Torres Strait Isla		Is this a new or recurrent case    New case			
Country of birthcountry Australia Overseas >	year arrived in Australia				
If born overseas, is the person currer  No Unknown					
Yes, is currently on a TB Health Und Interpreter required No Yes, language > 1	ərtakıng	Is the person a current in-patient in hospital  No Yes			
	phoratory datails	Form continues over page			
Notifying doctor / Hospital / Laboratory details    Notifying doctor name		Medicare provider no.   Treating unit			
Address / Hospital name / Laboratory name		Department use only			
City		Postcode			
Telephone	Fax	Date			

Please identify the Last name			First name		Date of birth			
case on every page								
Risk factors for Tuberculosis (tick all that apply)								
Household member or close contact with TB  Past travel to, or through, or residence in (for at least 3 months cumulative anytime in the case's life) in a high-risk country or countries  Australian-born child (aged less than 15 years) with one or more parents born in a high-risk country  Ever resided in a correctional facility  Ever resided in an aged care facility  Ever employed, volunteered or interned in:  An institution (correctional facility, aged care facility, homeless shelter)  The Australian health industry (including health laboratories)								
Health industry overseas (including health laboratories)  Currently working or in last 12 months worked, volunteered or interned in last 12 months in the:   Australian health industry (including health laboratories)								
Chest X-ray suggestive of old untreated TB  Immunosuppressive therapy:								
Medical summary — te	sting and site							
Specimen	Specimen date	Tests and re	esults					
Sputum		Microscopy Positive Negative Not done Unknown	Positive Negative Not done	Culture Positive Negative Not done Unknown				
Bronchial washings		Microscopy Positive Negative Not done Unknown	Positive Negative Not done	Culture Positive Negative Not done Unknown	Histolog Posit Nega Not c	ative done		
Other specimen, specify		Microscopy Positive Negative Not done Unknown	Positive Negative Not done	Culture Positive Negative Not done Unknown	Histolog Posit Nega Not o	tive ative done		
Date of chest X-ray / CT	Chest X-ray / CT results  Normal Abnormal - non-cavitary Abnormal - cavitary Not done Unknown	Details of ches	st X-ray / CT			Imaging type Chest X-ray CT MRI		
Site of disease  Pulmonary only Pulmonary plus other site(s), specify other site(s) > Genito/urinary Extra-pulmonary only, specify site(s) > Usymph nodes Meningeal  Other, specify other site(s) > Usymph other site(s) > Content of the site of the								
Treatment details								
Anti-tuberculosis treatment commencement date		ment regimen ithambutol						

Please advise your patient that a Clinical Nurse Consultant from the Victorian Tuberculosis Program will be contacting them following discharge. Arrangements will then be made for contact screening if required.

Other, specify >

For further information please contact the Victorian Tuberculosis Program on (03) 9342 9478.

Pyrazinamide