Notification of Sexually Transmitted Infection

State Government Victoria — Department of Human Services

Notification of the following sexually transmitted infections is required under the Health (Infectious Diseases) Regulations 2001. Please complete and send this notification form within five (5) days of diagnosis to: **Communicable Diseases, Department of Human Services, Reply Paid 65937, Melbourne VIC 8060 (no stamp required), or fax BOTH sides to 1300 651170.**

Case Details

Please print clearly. Tick boxes where applicable.

First two letters only:

Family Name **First Name** **Postcode of residence**

Sex
- ☐ Female
- ☐ Male

Date of Birth

Age (if birth date unknown) Years Months

Is the person of Aboriginal or Torres Strait Islander origin?
- ☐ No (non-Indigenous)
- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal & Torres Strait Islander
- ☐ Unknown

Where was the person born?
- ☐ Australia
- ☐ Overseas — Specify country and year of arrival in Australia

What language does the person speak at home?
- ☐ English
- ☐ Other — Specify language

Is the person alive?
- ☐ Alive
- ☐ Died due to this STI — Date of Death
- ☐ Died due to other causes

Case Definition

- ☐ ***Chlamydia trachomatis* infection**
- ☐ **Donovanosis**
- ☐ **Gonococcal infection**—Specify diagnosis site/specimen
  - ☐ Urethra ☐ Urine ☐ Cervix/vagina ☐ Other—specify
  - ☐ Rectum ☐ Eye ☐ Pharynx
- ☐ **Syphilis**
  - ☐ Primary
  - ☐ Secondary
  - ☐ Latent—early (< 2 years)
  - ☐ Latent—late (> 2 years)
  - ☐ Latent—unknown
  - ☐ Congenital—confirmed
  - ☐ Congenital—presumptive
  - ☐ Neurosyphilis
  - ☐ Other late syphilis
  - ☐ Other treponemal infection —Specify
  - ☐ Past adequately treated syphilis—Specify previous treatment

Has laboratory confirmation been requested?
- ☐ No
- ☐ Yes, pending at:
- ☐ Yes, confirmed at: *Laboratory*

Case History

Is the person pregnant?
- ☐ Yes—specify number of weeks gestation
- ☐ No

Why was the person tested?
- ☐ Blood donation screen
- ☐ STI screen suggested by doctor
- ☐ STI screen requested by patient
- ☐ Antenatal screen
- ☐ Patient presented with clinical symptoms or sign of an STI
- ☐ Abnormalities on examination
- ☐ Patient was an asymptomatic contact of an infected individual
- ☐ Pre-termination screen
- ☐ Dementia screen
- ☐ Other—specify

If symptomatic, specify onset of illness?

Where was this infection probably acquired?
- ☐ Victoria
- ☐ Interstate — Specify state or country
- ☐ Overseas — Specify state or country
- ☐ Don't know

From whom was this infection probably acquired?
- ☐ Casual partner
- ☐ Regular partner
- ☐ Sex worker
- ☐ Client (that is, the case is a sex worker)
- ☐ Don't know

...From above, this sexual partner was a:
- ☐ Female partner
- ☐ Male partner
- ☐ Transgender partner
- ☐ Don't know

What treatment was prescribed for this current episode? (Drug/dosage/duration)

Has partner notification (contact tracing) been initiated?
- ☐ Yes—patient will notify partner/s
- ☐ Yes—doctor will notify partner/s
- ☐ No—For assistance, please contact DHS partner notification officers on 03 9347 1899
- ☐ No—I do not require assistance

Form completed by:

Notifying Doctor/Laboratory/Hospital Details

Name of Notifying Doctor, Laboratory or Hospital

Address

City/Suburb/Town **Postcode**

Telephone **Signature** **Date**

DHS Use Only

320

Check: CC: