Government of Western Australia
Department of Health

NOTIFICATION OF INTUSSUSCEPTION

20 ___ Notification ID

NOTIFY TO:
Communicable Disease Control Directorate
PO Box 8172, Perth Business Centre WA 6849
PHONE 08 9388 4852 or
FAX 08 9388 4848

NOTIFYING DOCTOR DETAILS

Name of surgical consultant .....

Name of doctor completing this form .....

Hospital/clinic .....

Telephone .....

Signature ..... **Date** _____/_____/_____
dd / mm / yyyy

PATIENT DETAILS

Family name .....

Given name .....

Address .....

Suburb/Town ..... **Postcode** ☐☐☐☐

Telephone (home) .....

Mobile .....

Date of birth _____/_____/_____
dd / mm / yyyy

Sex ☐ Male ☐ Female

Is the patient Aboriginal or Torres Strait Islander?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

For persons of both Aboriginal and Torres Strait Islander origin, tick both "Yes" boxes

ADMISSION DETAILS

Date admitted for intussusception _____/_____/_____

Hospital .....

If the patient was transferred from another hospital, please specify the hospital .....

Date admitted to referring hospital _____/_____/_____

PATIENT HISTORY

Has the patient had a previous episode of intussusception?

☐ Yes ☐ No ☐ Unknown

If "Yes", please specify how many previous episodes and at what age (months) the episode(s) occurred.

.....

.....

Is there any known history of intussusception in the family?

☐ Yes ☐ No ☐ Unknown

VACCINATION DETAILS

Has the patient ever received a rotavirus vaccine?

☐ Yes ☐ No ☐ Unknown

If "Yes" please specify date and type of vaccine (Rotarix®/Rotateq®) given:

Date	Vaccine	Batch Number
_____/_____/_____		
_____/_____/_____		
_____/_____/_____		

Has the patient received any other vaccines within two weeks prior to the onset of the intussusception episode?

☐ Yes ☐ No ☐ Unknown

If "Yes" which vaccine(s) did they receive? (Tick one or more)*

☐ HepB ☐ DTPa ☐ IPV
☐ Hib ☐ 7vPCV ☐ 23vPPV
☐ MMR ☐ MenCCV ☐ VZV
☐ Other *(specify)* .....

Date of last immunisation _____/_____/_____ ☐ Unknown

CLINICAL DETAILS AND OUTCOME

How was the diagnosis of intussusception made? (*Tick one or more*)

☐ Enema
☐ Ultrasound
☐ Abdominal x-ray
☐ Surgery
☐ Other *(please specify)* .....

Site of intussusception (eg. Ascending colon) .....

Type of intussusception (eg. Ileocaecal) .....

What was the duration of symptoms prior to diagnosis?

☐ <12 hours ☐ 12-23 hours ☐ 24-48 hours
☐ 49-72 hours ☐ >72 hours ☐ Unknown

How was the intussusception episode resolved?

☐ Barium enema
☐ Self-resolved
☐ Surgery
☐ Other *(please specify)* .....

Patient outcome

☐ Alive ☐ Died

If the patient "Died", please specify the date of death ____/____/_____

SPECIMEN DETAILS

Was a stool specimen collected?

☐ Yes ☐ No ☐ Unknown

If "Yes", what date was the specimen collected? _____/_____/_____

*Vaccines: HepB, hepatitis B; DTPa, diphtheria-tetanus-pertussis acellular; IPV, inactivated poliomyelitis; Hib, *Haemophilus influenzae* type b; 7vPCV, 7-valent pneumococcal conjugate; 23vPPV, 23-valent pneumococcal polysaccharide; MMR, measles-mumps-rubella; MenCCV, meningococcal C conjugate; VZV, varicella zoster