

# Malaria

## PATIENT DEMOGRAPHICS

Name (last, first): \_\_\_\_\_  
 Address (mailing): \_\_\_\_\_  
 Address (physical): \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Phone (home): \_\_\_\_\_ Phone (work/cell): \_\_\_\_\_  
 Alternate contact:  Parent/Guardian  Spouse  Other  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth date: \_\_/\_\_/\_\_\_\_ Age: \_\_\_\_  
 Sex:  Male  Female  Unk  
 Ethnicity:  Not Hispanic or Latino  
 Hispanic or Latino  Unk  
 Race:  White  Black/Afr. Amer.  
 Asian  Am. Ind/AK Native  
 Native HI/Other PI  Unk

## INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): \_\_\_\_\_  
 Investigation Start Date: \_\_/\_\_/\_\_\_\_  
 Earliest date reported to LHD: \_\_/\_\_/\_\_\_\_  
 Earliest date reported to DIDE: \_\_/\_\_/\_\_\_\_

Entered in WVEDSS?  Yes  No  Unk  
 Case Classification:  
 Confirmed  Probable  Suspect  
 Not a case  Unknown

## REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source:  Laboratory  Hospital  HCP  Public Health Agency  Other  
 Reporter Name: \_\_\_\_\_ Reporter Phone: \_\_\_\_\_  
 Primary HCP Name: \_\_\_\_\_ Primary HCP Phone: \_\_\_\_\_

## CLINICAL

Onset date: \_\_/\_\_/\_\_\_\_ Diagnosis date: \_\_/\_\_/\_\_\_\_ Recovery date: \_\_/\_\_/\_\_\_\_

### Symptoms and Clinical Findings

- Y N U  
   Fever (Highest measured temperature: \_\_\_\_ °F)  
   Chills  
   Sweats  
   Headache  
   Myalgia  
   Nausea  
   Vomiting  
   Fatigue  
   Confusion  
   Neurologic focal signs

### Complications

- Y N U  
   Acute respiratory distress syndrome (ARDS)  
   Coma  
   Cerebral malaria  
   Kidney failure  
   Liver failure

### Clinical Risk Factors

- Y N U  
   Underlying medical condition  
   History of malaria in previous 12 months (if yes, indicate species below)  
 Vivax  Falciparum  Ovale  Malariae  Unknown

### Hospitalization

- Y N U  
   Patient hospitalized for this illness  
 If yes, hospital name: \_\_\_\_\_  
 Admit date: \_\_/\_\_/\_\_\_\_ Discharge date: \_\_/\_\_/\_\_\_\_

### Death

- Y N U  
   Patient died due to this illness If yes, date of death: \_\_/\_\_/\_\_\_\_

## TREATMENT

- Y N U  
   Patient received therapy for this attack (If yes, indicate type below)  
 Chloroquine  Tetracycline  Doxycycline  
 Mefloquine  Exchange transfusion  Artesunate  
 Unknown  Primaquine  Quinine  
 Quinidine  Atovaquone/proguanil  Other: \_\_\_\_\_

## LABORATORY (Please submit copies of all labs, including CBCs, associated with this illness to DIDE)

- Y N U  
   Anemia  
   Demonstration of *Plasmodium* species in blood films (parasitemia: \_\_\_\_%)  
   Demonstration of *Plasmodium* species by molecular testing (e.g. PCR)  
   Detection of *Plasmodium* species by RDT without confirmation by microscopy or molecular testing (symptomatic or asymptomatic)  
   Specimen(s) sent to CDC for testing ( Smear  Whole blood  Other: \_\_\_\_\_)

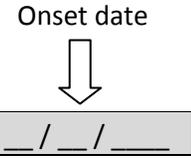
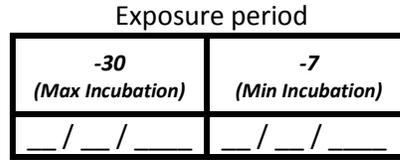
If the species of *Plasmodium* has been identified from any of the above test methods, please specify:

- Vivax  Falciparum  Ovale  Malariae  Unable to identify  Other species (specify: \_\_\_\_\_)

**INFECTION TIMELINE**

*Instructions: Enter onset date in grey box. Count backward to determine probable exposure period*

Days from onset  
Calendar dates:



\* Incubation period for infection from transfusion may be up to 2 months. Some *P. vivax* strains have protracted incubation (8 to 10 months).

**EPIDEMIOLOGIC EXPOSURES (based on the above exposure period, unless otherwise noted)**

Y N U

History of travel during exposure period (if yes, complete travel history below):

Destination (City, County, State and Country)	Arrival Date	Departure Date	Reason for travel

Y N U

- Patient traveled (or lived) outside of United States during the past **2 years**
- Patient resided in United States prior to most recent travel  
If no, please specify country: \_\_\_\_\_
- Foreign arrival (e.g. immigrant, adoptee, etc)  
If yes, country: \_\_\_\_\_
- Blood transfusion recipient within last **12 months**  
If yes, date: \_\_/\_\_/\_\_\_\_
- Organ transplant recipient within last **12 months**  
If yes, date: \_\_/\_\_/\_\_\_\_

Where did exposure most likely occur? County: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**PUBLIC HEALTH ISSUES**

Y N U

- Malaria chemoprophylaxis taken (if yes, indicate below)
  - Chloroquine     Mefloquine     Doxycycline
  - Primaquine     Atovaquone/proguanil     Other: \_\_\_\_\_
- All chemoprophylaxis medications taken as prescribed  
If doses were missed or not taken, please specify reason:
  - Forgot     Didn't think needed     Side effects
  - Told to stop     Prematurely stopped taking once home
  - Unknown     Other: \_\_\_\_\_
- Case donated blood products, organs or tissue in the 30 days prior to symptom onset  
Date: \_\_/\_\_/\_\_\_\_  
Agency/location: \_\_\_\_\_  
Type of donation: \_\_\_\_\_
- Case is pregnant (Due date: \_\_/\_\_/\_\_\_\_)
- Case knows someone who had shared exposure and is currently having similar symptoms
- Epi link to another confirmed case of same condition
- Case is part of an outbreak
- Other:

**PUBLIC HEALTH ACTIONS**

Y N U

- Notify blood or tissue bank or other facility where organs donated
- Notify patient obstetrician
- Disease education and prevention information provided to patient and/or family/guardian
- Facilitate laboratory testing of other symptomatic persons who have a shared exposure
- Patient is lost to follow-up
- Other:

**WVEDSS**

Y N U

Entered into WVEDSS (Entry date: \_\_/\_\_/\_\_\_\_)    Case Status:     Confirmed     Probable     Suspect     Not a case     Unknown

**NOTES**

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