

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:

Exposure period	
-30 <i>(Max Incubation)</i>	-7 <i>(Min Incubation)</i>
__/__/__	__/__/__

Onset date

↓
 __/__/__

* 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