MALARIA CASE SURVEILLANCE REPORT

Department of Health and Human Services, Centers for Disease Control and Prevention
Division of Parasitic Diseases (MS F-22), 4770 Buford Highway, N.E. Atlanta, Georgia 30341

Part I

State Case No: ..... CSID No..... Case No: .....

Patient name (last, first):

Date of symptom onset of **this** attack (mm/dd/yyyy): ____/ ____/ _____

Age: _____ **yrs. mos. wks. days** (*circle units*)
Date of Birth: ____/ ____/ _____
Is patient pregnant? ☐ Yes ☐ No
Height: ____ **ft. and** _____**in.** Weight:____ **lbs.**

Sex:
☐ Male
☐ Female
☐ Unknown

Physician name (last, first):

Telephone Number: ( ) _____ – _____

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (select one or more):
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Black or African American
☐ Asian ☐ White ☐ Unknown

Positive lab test result (*check all that apply*):
☐ Smear ☐PCR ☐RDT ☐ No test done/unknown

Species (check all that apply):
☐ Vivax ☐ Falciparum ☐Malariae ☐ Ovale ☐ Not Determined
☐ Other species (specify) _____

Parasitemia (%): _____

State/territory reporting this case: _____
County: _____

Patient admitted to hospital: ☐ Yes ☐ No ☐ Unknown

Hospital: _____

Date: ____/ ____/ _____ Hospital record No.: _____

Laboratory name:

Telephone Number: ( ) _____ – _____

Specimens being sent to CDC? ☐ Yes ☐ No ☐ Unknown

If yes: ☐ Smears ☐ Whole Blood ☐ Other: _____

Has the patient traveled or lived outside the U.S. during the past 2 years? ☐Yes ☐ No If yes, specify:

	1.	2.	3.
Country:	_____	_____	_____
Date returned/ arrived in U.S. (mm/dd/yyyy):	____/ ____/ _____	____/ ____/ _____	____/ ____/ _____
Duration in country **yrs. mos. wks. days** (*circle units*)	_____	_____	_____

Did patient reside in U.S. prior to most recent travel?
☐ Yes
☐ No, (specify country): _____
☐ Unknown

Principal reason for travel from/ to U.S. for most recent trip:
☐ Tourism ☐ Visiting friends/relatives ☐ Student/teacher
☐ Military ☐ Airline/ship crew ☐ Other: _____
☐ Business ☐ Missionary or dependent ☐ Unknown
☐ Peace Corps ☐ Refugee/immigrant

Was malaria chemoprophylaxis taken? ☐ Yes ☐ No ☐ Unknown
If yes, which drugs were taken? ☐ Chloroquine ☐ Mefloquine ☐ Doxycycline ☐ Primaquine ☐ Atovaquone/proguanil
☐ Other: _____ ☐ Unknown

Was chemoprophylaxis taken as prescribed?
☐ Yes, missed no doses
☐ No, missed doses
☐ Unknown

If doses were missed, what was the reason?
☐ Forgot
☐ Didn't think needed
☐ Had a side effect (specify): _____
☐ Was advised by others to stop
☐ Prematurely stopped taking once home
☐ Other (specify): _____
☐ Unknown

History of malaria in last 12 months (prior to this report)?
☐ Yes ☐ No ☐ Unknown
Date of previous illness: ____/ ____/ _____
If yes, species (check all that apply):
☐Vivax ☐ Falciparum ☐Malariae ☐ Ovale
☐Not Determined ☐ Other (specify) _____

Blood transfusion/organ transplant within last 12 months: ☐ Yes ☐ No ☐ Unknown If yes, date: ____/ ____/ _____

Clinical Complications: ☐ Cerebral malaria ☐ ARDS ☐ None ☐ Renal failure ☐ Severe anemia(Hb<7) ☐ Other : _____
Was illness fatal: ☐ Yes ☐ No ☐ Unknown
If yes, date of death : _____/____/_____

Therapy for this attack (check all that apply):
☐ Chloroquine ☐ Tetracycline ☐ Doxycycline ☐Mefloquine ☐ Exchange transfusion ☐ Artesunate ☐ Artemether/lumefantrine ☐ Unknown
☐ Primaquine ☐ Quinine ☐ Quinidine ☐Clindamycin ☐Atovaquone/proguanil ☐ Other (specify): _____

Person submitting report: Telephone No. :

Affiliation: Date Submitted: _____/_____/_____

For CDC Use Only. Classification ☐ Imported ☐ Induced ☐ Introduced ☐ Congenital ☐ Cryptic

If sending specimens, please forward blood smears (thick and thin) with this report.

Physicians and other health care providers with questions about diagnosis and treatment of malaria cases can call CDC's Malaria Hotline:

- Monday – Friday, 9:00 am to 5 pm, EST: call 770-488-7788 or 855-856-4713 (Fax: 404-718-4815)
- Off-hours, weekends, and federal holidays: call 770-488-7100 and ask to have the malaria clinician on call paged.

Information on malaria risk, prevention, and treatment is available at:

CDC's Malaria Web site http://www.cdc.gov/malaria

Part II (to be complete 4 weeks after treatment)

Please list all prescription and over the counter medicines the patient had taken during the 2 weeks **before** starting their treatment for malaria.

Please list all prescription and over the counter medicines the patient had taken during the 4 weeks **after** starting their treatment for malaria.

Was the medicine for malaria treatment taken as prescribed? ☐ No, doses missed ☐ Yes, no doses missed ☐ Unknown

Did all signs or symptoms of malaria resolve without any additional malaria treatment within 7 days after treatment start?
☐ Yes ☐ No ☐ Unknown

If yes, did the patient experience a recurrence of signs or symptoms of malaria during the 4 weeks after starting malaria treatment?
☐ Yes ☐ No ☐ Unknown

Did the patient experience any adverse events within 4 weeks after receiving the malaria treatment? ☐ Yes ☐ No ☐ Unknown

(If Yes): Event description	Relationship to treatment suspected*	Time to Onset since treatment start	Fatal?	Life-Threatening?	Other Seriousness?**
1 _____	☐	_____	☐	☐	☐
2 _____	☐	_____	☐	☐	☐
3 _____	☐	_____	☐	☐	☐
4 _____	☐	_____	☐	☐	☐
5 _____	☐	_____	☐	☐	☐

* Suspected means that a causal relationship between the treatment and an adverse event is at least a reasonable possibility, i.e., the relationship cannot be ruled out.

** A *serious* adverse event is defined as an event which is fatal or life-threatening, results in persistent or significant disability/incapacity, constitutes a congenital anomaly/birth defect, is medically significant (i.e., jeopardizes the patient or may require medical or surgical intervention), or requires inpatient hospitalization or prolongation of existing hospitalization.