



# 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



State Case No: .....

Case No: .....

Form Approved

DASH No: .....

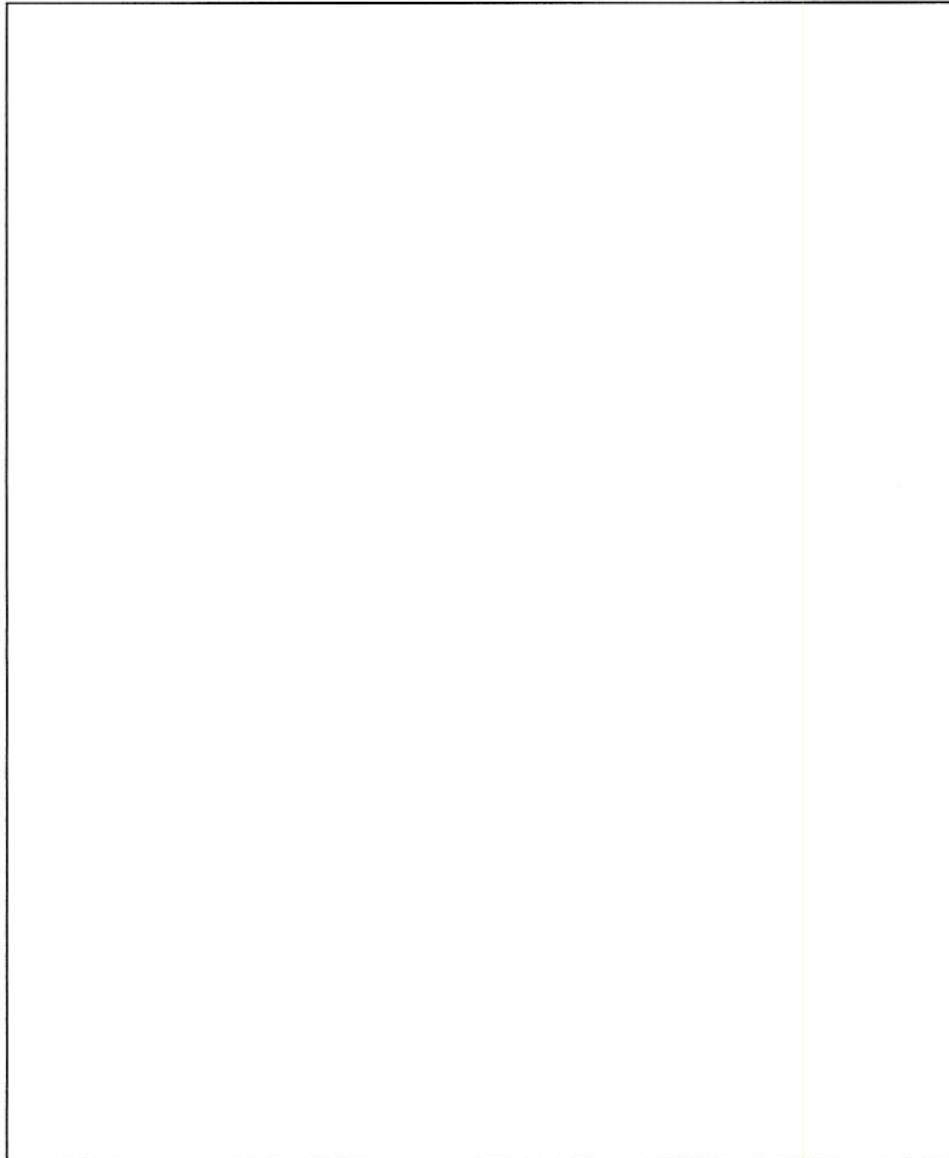
County: .....

OMB 0920-0009

Patient name (last, first):		Age (yrs): _____ (mos): _____	Sex: <input type="checkbox"/> Male
Date of symptom onset of this attack (mm/dd/yyyy): ___/___/___		Date of birth: ___/___/___	<input type="checkbox"/> Female
Physician name (last, first):		Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Telephone No: ( ) _____ - _____		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	Race (select one or more): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown
Lab results: <input type="checkbox"/> Smear positive <input type="checkbox"/> Smear Negative <input type="checkbox"/> No Smear Taken		State/territory reporting this case: _____	
Species (check all that apply): <input type="checkbox"/> Vivax <input type="checkbox"/> Falciparum <input type="checkbox"/> Malariae <input type="checkbox"/> Ovale <input type="checkbox"/> Not Determined		Patient admitted to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Laboratory name: Telephone No: ( ) _____ - _____		Hospital: _____ Date: ___/___/___ Hospital record No.: _____	
Has the patient traveled or lived outside the U.S. during the past 4 years? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify:	
Country: 1. _____ 2. _____ 3. _____			
Date returned/arrived in U.S. (mm/dd/yyyy): ___/___/___			
Duration of stay in foreign country (days): _____			
Did patient reside in U.S. prior to most recent travel? <input type="checkbox"/> Yes, for ≥12 months <input type="checkbox"/> Yes, for <12 months <input type="checkbox"/> No, (specify country): _____ <input type="checkbox"/> Unknown		Principal reason for travel from/to U.S. for most recent trip: <input type="checkbox"/> Tourism <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Student/teacher <input type="checkbox"/> Military <input type="checkbox"/> Airline/ship crew <input type="checkbox"/> Other: _____ <input type="checkbox"/> Business <input type="checkbox"/> Missionary or dependent <input type="checkbox"/> Peace Corps <input type="checkbox"/> Refugee/immigrant	
Was malaria chemoprophylaxis taken? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, which drugs were taken? <input type="checkbox"/> Chloroquine <input type="checkbox"/> Mefloquine <input type="checkbox"/> Doxycycline <input type="checkbox"/> Primaquine <input type="checkbox"/> Malarone® <input type="checkbox"/> Other: _____	
Were all pills taken as prescribed? <input type="checkbox"/> Yes, missed no doses <input type="checkbox"/> No, missed one to a few doses <input type="checkbox"/> No, missed more than a few but less than half of the doses <input type="checkbox"/> No, missed half or more of the doses <input type="checkbox"/> No, missed doses but not sure how many <input type="checkbox"/> Don't know		If doses were missed, what was the reason? <input type="checkbox"/> Forgot <input type="checkbox"/> Didn't think needed <input type="checkbox"/> Had a side effect (specify): _____ <input type="checkbox"/> Was advised by others to stop <input type="checkbox"/> Prematurely stopped taking once home <input type="checkbox"/> Other (specify): _____	
History of malaria in last 12 months (prior to this report)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of previous illness: ___/___/___	
If yes, species (check all that apply): <input type="checkbox"/> Vivax <input type="checkbox"/> Falciparum <input type="checkbox"/> Malariae <input type="checkbox"/> Ovale <input type="checkbox"/> Not Determined			
Blood transfusion/organ transplant within last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date: ___/___/___	
Clinical complications for this attack: <input type="checkbox"/> Cerebral malaria <input type="checkbox"/> ARDS <input type="checkbox"/> None <input type="checkbox"/> Renal failure <input type="checkbox"/> Anemia <input type="checkbox"/> Other: _____ (Hb<11, Hct<33)		Was illness fatal: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date of death: ___/___/___	
Therapy for this attack (check all that apply): <input type="checkbox"/> Chloroquine <input type="checkbox"/> Tetracycline/doxycycline <input type="checkbox"/> Mefloquine <input type="checkbox"/> Exchange transfusion <input type="checkbox"/> Unknown <input type="checkbox"/> Primaquine <input type="checkbox"/> Quinine/quinidine <input type="checkbox"/> Pyrimethamine-sulfadoxine <input type="checkbox"/> Malarone <input type="checkbox"/> Other (specify): _____			
Person submitting report: _____		Telephone No.: _____	
Affiliation: _____		Date: ___/___/___	
For CDC Use Only. Classification <input type="checkbox"/> Imported <input type="checkbox"/> Induced <input type="checkbox"/> Introduced <input type="checkbox"/> Congenital <input type="checkbox"/> Cryptic			

Public reporting burden of this collection of information is estimated to average 15 minutes per response. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Please send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Rd., NE (MS D-24), Atlanta, GA 30333; ATTN: PRA (0920-0009).

CDC 54.1 01/2002 (Front) 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, 8:00 am to 4:30 pm, EST: call 770-488-7788 (Fax: 770-488-4206)
- 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 Travelers' Health Web site <http://www.cdc.gov/travel>
- CDC's Travelers' Health Information Service: call 1-877-FYI-TRIP
- CDC's Malaria Web site <http://www.cdc.gov/malaria>

***Health Information for International Travel* is available from the Public Health Foundation:**

Call 1-877-252-1200, or order on line at <http://www.phf.org>