



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: ____/____/____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Height: __ ft. and __ in. Weight: _____ lbs./kgs (circle units)
Physician name (last, first): _____ Telephone Number: () _____ - _____	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino Race (select one or more): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown
Positive lab test result (check all that apply): <input type="checkbox"/> Smear <input type="checkbox"/> PCR <input type="checkbox"/> RDT <input type="checkbox"/> No test done/unknown 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 <input type="checkbox"/> Other species (specify) _____ Parasitemia (%): _____	State/territory reporting this case: _____ County: _____ Patient admitted to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hospital: _____ Date: ____/____/____ Hospital record No.: _____
Laboratory name: _____ Telephone Number: () _____ - _____	Specimens being sent to CDC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes: <input type="checkbox"/> Smears <input type="checkbox"/> Whole Blood <input type="checkbox"/> Other: _____

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

Country: 1. _____ 2. _____ 3. _____

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? <input type="checkbox"/> Yes <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"/> Unknown <input type="checkbox"/> Peace Corps <input type="checkbox"/> Refugee/immigrant
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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? <input type="checkbox"/> Yes, missed no doses <input type="checkbox"/> No, missed doses <input type="checkbox"/> Unknown	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): _____ <input type="checkbox"/> Unknown	History of malaria in last 12 months (prior to this report)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 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 <input type="checkbox"/> Other (specify) _____
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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

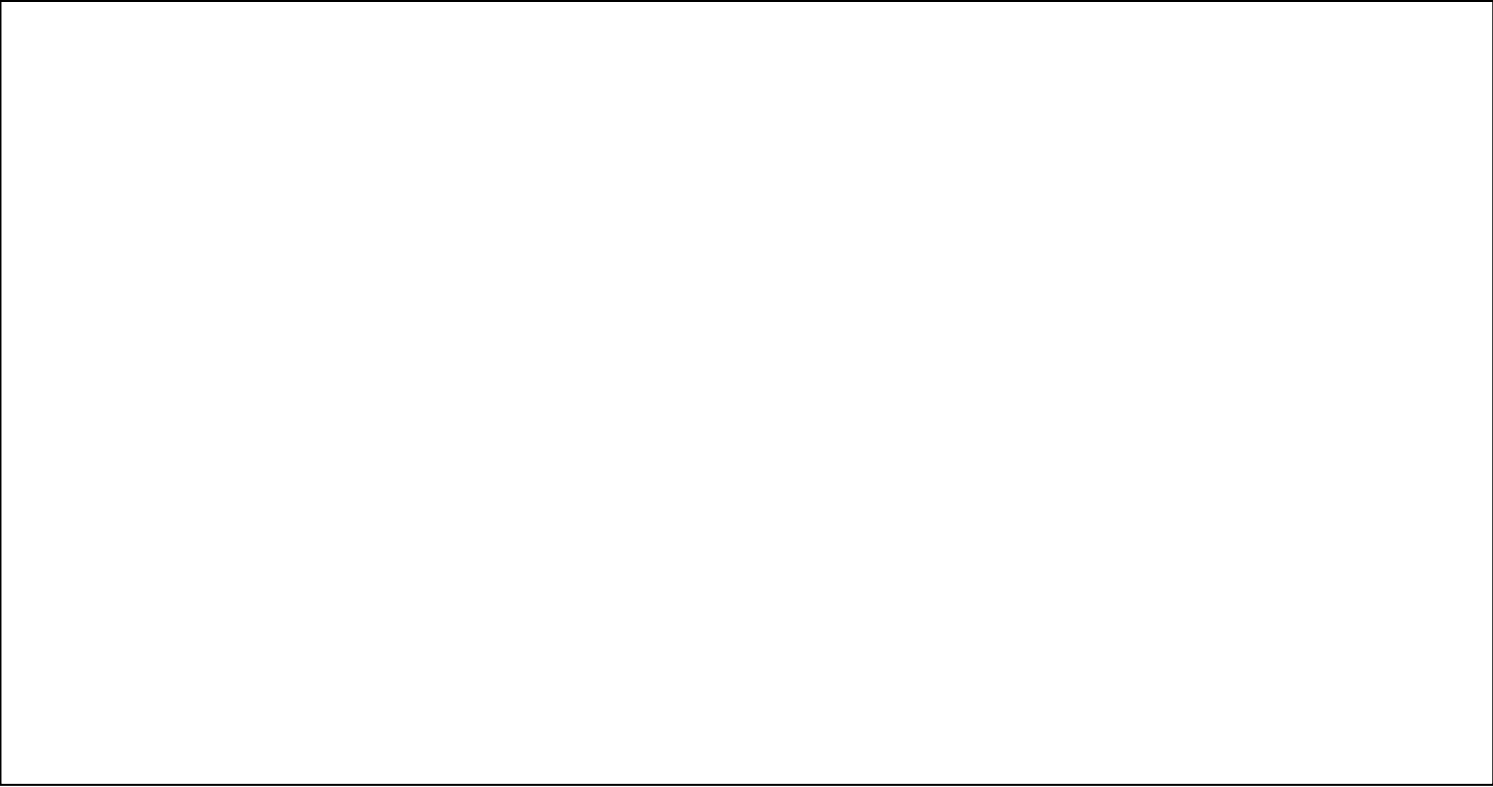
Primaquine Quinine Quinidine Clindamycin Atovaquone/proguanil Other (specify): _____

Person submitting report: _____ Telephone No. : _____

Affiliation: _____ Date Submitted: ____/____/____

For CDC Use Only. Classification Imported Induced Introduced Congenital Cryptic

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).



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 (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 Malaria Web site <http://www.cdc.gov/malaria>

Part II (to be complete 4 weeks after treatment)

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

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

Medicine for malaria treatment taken as prescribed? No, doses missed Yes, no doses missed Unknown

Do signs or symptoms of malaria resolve without any additional 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

Event description	Relationship to treatment suspected*	Time to Onset since treatment start	Fatal?	Life-Threatening?	Other Seriousness?***
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Relationship to treatment 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.

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