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./kgs (*circle units*)

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 : _____/____/_______

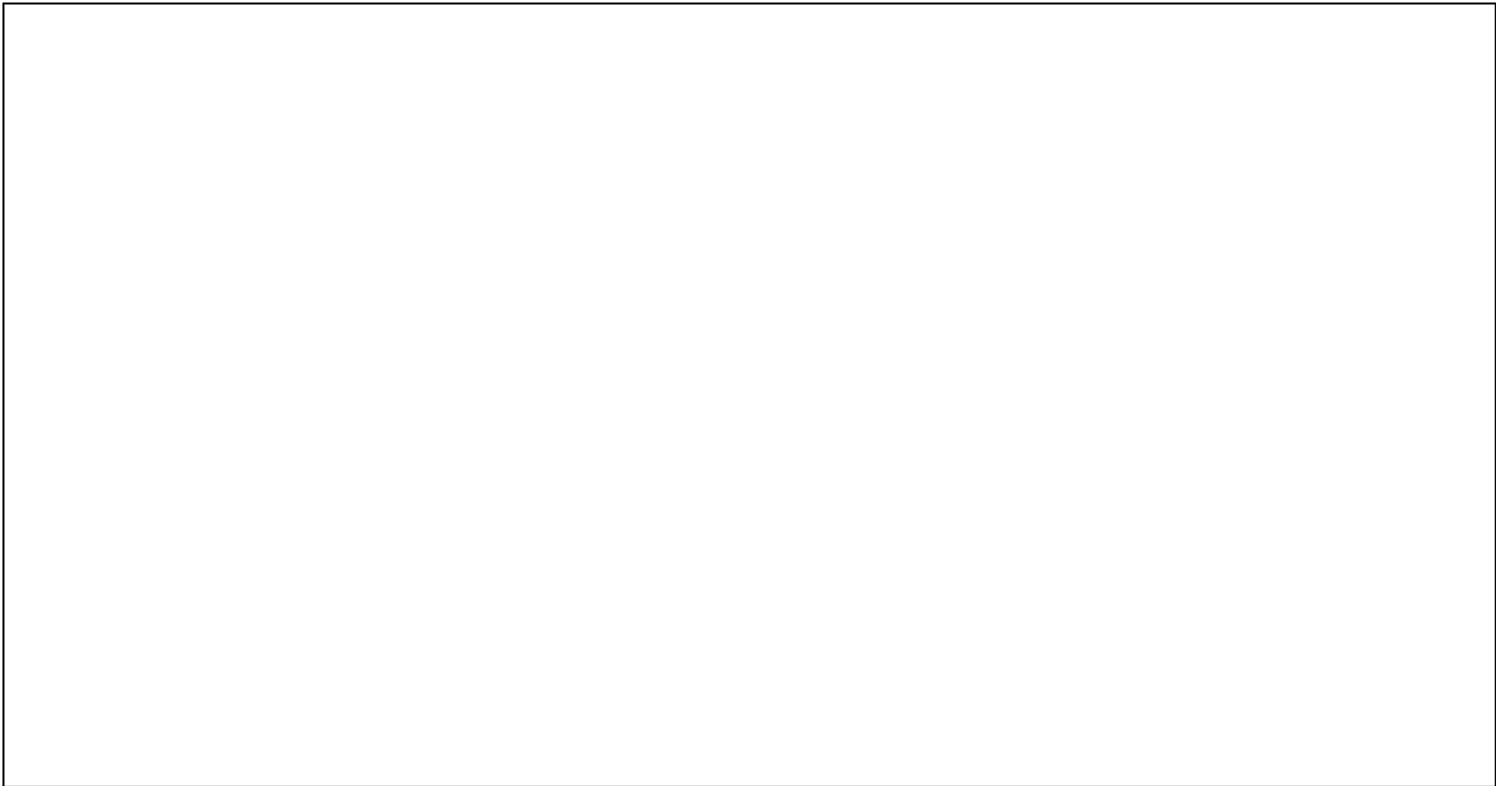
Therapy for this attack (check all that apply):
☐ Chloroquine ☐ Tetracycline ☐ Doxycycline ☐ Mefloquine ☐ Exchange transfusion ☐ Artesunate ☐ Artemether/lumefantrine ☐ Unknown
☐ Primaquine ☐ Quinine ☐ Quinidine ☐ Clindamycin ☐ Atovaquone/proguanil ☐ Other (specify): ______________________________

Person submitting report: Telephone No. :
Affiliation: Date Submitted: __________/__________/_____________

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

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).

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 (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)

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

____

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

____

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

s or symptoms of malaria resolve without any additional tment 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

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

ent description	Relationship to treatment suspected*	Time to Onset since treatment start	Fatal?	Life-Threatening?	Other Seriousness?**
______________	☐	________	☐	☐	☐
______________	☐	________	☐	☐	☐
______________	☐	________	☐	☐	☐
______________	☐	________ ☐	☐	☐	☐
______________	☐	________ ☐	☐	☐	☐

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eans 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.

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 f existing hospitalization