**EBOLA / MALARIA ASSESSMENT**

Approved Form

OMB No. 0920-1026

Exp. Date: 07/31/2017





OMB Approved

0920-XXXX

Expiration Date xx/xx/xxxx

CDC Assigned ID: ....................... State/territory reporting this case: ..................................... Case No: .........................

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| 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:  Male   Female  Unknown | |
| Physician name (last, first):  Telephone Number: ( ) \_\_\_\_\_\_\_\_\_ – \_\_\_\_\_\_\_\_\_\_\_ | Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown | Race (select one or more):  American Indian/Alaska Native  Native Hawaiian/Other Pacific Islander  Black or African American  Asian  White  Unknown |

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| **Symptom History** | **Yes** | **No** | **When did the  fever start?** | When did the patient first seek medical attention:  Date: \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_\_\_  Patient admitted to hospital:  Yes  No  Unknown  Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_\_\_ Hospital record No.: \_\_\_\_\_\_\_\_  Was the patient admitted to the ICU:  Yes  No  Unknown  Date: \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_\_\_  Initial diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (ICD-9 code)  Final diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (ICD-9 code)  Is the patient insured?  Yes  No  Unknown |
|  |  |  |  |
| Fever |  |  | \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_\_\_ |
| Nausea |  |  |  |
| Vomiting |  |  |  |
| Diarrhea |  |  |  |
| Upper respiratory symptoms (cough, congestion) |  |  |  |
| Rash |  |  |  |
| Altered mental status |  |  |  |
| Jaundice |  |  |  |
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| **Laboratory Tests** | | | | | | | | | | |
|  | **Yes** | **No** | **Unknown** | **Date and time test done**  **mm/dd/yyyy hh:mm** | | | **Results** | **Date and time results available mm/dd/yyyy hh:mm** | | |
| **CBC** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm | N/A | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |
| **Chemistry panel** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm | N/A | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |
|  |  |  |  |  |  |  |  |  |  |  |
| **Tested for malaria?** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |  |  |  |  |
| **Microscopy  Thin Smear** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm | positive  negative | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |
| **Microscopy  Thick Smear** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm | positive  negative | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |
| **RDT (Binax Now)** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm | positive  negative | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |
| **PCR** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm | positive  negative | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |
| **Antibody testing** |  |  |  | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm | positive  negative | \_\_\_/\_\_\_/\_\_\_\_\_\_ | \_\_ \_\_ : \_\_ \_\_ | am  pm |

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| **Species** (*check all that apply*)  Vivax  Falciparum Malariae  Ovale  Not Determined Other species (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parasitemia (%): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Public reporting burden of this collection of information is estimated to average 5 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 (0920-1026).

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| Was a travel history taken for this patient? Yes  No  Unknown | | | | | | | |
| Is the patient a US resident? Yes  No  Unknown | | | | | | | |
| Has the patient traveled or lived outside the U.S. since December 2013?  Yes  No If yes, specify: | | | | | | | |
| Country: | | 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Date ARRIVED IN the country (mm/dd/yyyy):  Date DEPARTED the country (mm/dd/yyyy): | | \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_  \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_ | | \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_  \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_ | | \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_  \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_\_ | |
|  | |  | |  | |  | |
| Clinical  Cerebral malaria  ARDS  None Was illness fatal:  Yes  No  Unknown  Complications:  Renal failure  Severe anemia(Hb<7)  Other : \_\_\_\_\_\_\_\_\_\_\_\_ If yes, date of death : \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | | | | | | | |
|  | | | | | | | |
| **Therapy for this attack (check all that apply)** | **Was this medication given?** | | **Date and time medication given  mm/dd/yyyy hh:mm** | | | | |
| Artemether/lumefantrine (Coartem) | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Artesunate | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Atovaquone-Proguanil (Malarone) | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Chloroquine | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Clindamycin | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Doxycycline | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Mefloquine | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Quinidine | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Quinine | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes  Unknown  No | | \_\_\_/\_\_\_/\_\_\_\_\_\_ | | \_\_ \_\_ : \_\_ \_\_ | | am  pm |