EBOLA / 1MALARIA ASSESSMENT

Approved Form
OMB No. 0920-1026
Exp. Date: 07/31/2017

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

Patient name (last, first):

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

Physician name (last, first):

Telephone Number: ( ) _____ – _____

Age: _____ **yrs. mos. wks. days** (*circle one*)
Date of Birth: _____/ _____/ _____
Sex: ☐ Male ☐ Female ☐ Unknown

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

Symptom History	Yes	No	When did the fever start?
Fever	☐	☐	____/ ____/ _____
Nausea	☐	☐	
Vomiting	☐	☐	
Diarrhea	☐	☐	
Upper respiratory symptoms (cough, congestion)	☐	☐	
Rash	☐	☐	
Altered mental status	☐	☐	
Jaundice	☐	☐	

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

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 ___/___/_____ __ __ : __ __

Current Approved
0920-XXXX
Expiration Date xx/xx/xxxx

RDT (Binax Now)	☐	☐	☐	☐ am ☐ pm ___/___/_____ __ __ : __ __	☐ positive ☐ negative	☐ am ☐ pm ___/___/_____ __ __ : __ __
PCR	☐	☐	☐	☐ am ☐ pm ___/___/_____ __ __ : __ __	☐ positive ☐ negative	☐ am ☐ pm ___/___/_____ __ __ : __ __
Antibody testing	☐	☐	☐	☐ am ☐ pm ___/___/_____ __ __ : __ __	☐ positive ☐ negative	☐ am ☐ pm ___/___/_____ __ __ : __ __

Species (*check all that apply*)

☐ Vivax ☐ Falciparum ☐ Malariae ☐ Ovale ☐ Not Determined ☐ Other species (specify) _____
Parasitemia (%): _____

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 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)	**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