Malaria

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: First and middle name: Maiden name: Suffix: Address line: Zip: City: State: County: Phone: ( )- - Type: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown Date of Death / /
Event exception: ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: ***Plasmodium*** Type (e.g. serotype): ☐ *ovale* ☐ *vivax* ☐ *malariae* ☐ *falciparum*

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Result date: / /
Result type: ☐ Preliminary ☐ Final Test type: Result: ☐ Positive ☐ Negative
Organism: ***Plasmodium*** Type (e.g. serotype): ☐ *ovale* ☐ *vivax* ☐ *malariae* ☐ *falciparum*

Laboratory: __________ Accession #: __________ Collection date: __/__/__

Date received: __/__/__ Specimen source: __________ Result date: __/__/__

Result type: ☐ Preliminary ☐ Final Test type: __________ Result: ☐ Positive ☐ Negative

Organism: ***Plasmodium*** Type (e.g. serotype): ☐ *ovale* ☐ *malariae* ☐ *vivax* ☐ *falciparum*

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: Job title: __________

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: __________

Date worked from: __/__/__ Address: __________

Date worked to: __/__/__ Zip code: __________

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: __________ State: ______ County: __________

Date removed: __/__/__ Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown Direct patient care duties in
Attend school: ☐ Yes ☐ No ☐ Unknown lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown Health care worker type:

Occupation type: Job title: __________

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: __________

Date worked from: __/__/__ Address: __________

Date worked to: __/__/__ Zip code: __________

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: __________ State: ______ County: __________

Date removed: __/__/__ Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown Direct patient care duties in
Attend school: ☐ Yes ☐ No ☐ Unknown lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: __________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry):

Admission date: __/__/__ Discharge date: __/__/__ Days hospitalized: __________

Currently isolated: ☐ Yes ☐ No ☐ Unknown Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms:
☐ Fever ☐ Anorexia ☐ Backache
☐ Chills ☐ Cough ☐ Encephalitis ☐ Fatigue
☐ Headache ☐ Hypoglycemia ☐ Joint pain ☐ Muscle pain
☐ Nausea ☐ Otitis media ☐ Photophobia ☐ Pneumonia
☐ Renal failure ☐ Sweats

Complications: ☐ Anemia ☐ ARDS ☐ Cerebral malaria ☐ Renal failure

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:
☐ Artemether ☐ Artesunate ☐ Chloroquine ☐ Doxycycline ☐ Lumefantrine ☐ Mefloquine
☐ Quinidine gluconate ☐ Quinine dihydrochloride ☐ Sulfadoxine-pyrimethamine ☐ Tetracycline ☐ Other
Date started: __/__/__
Dose: __________

Antibiotic:
☐ Artemether ☐ Artesunate ☐ Chloroquine ☐ Doxycycline ☐ Lumefantrine ☐ Mefloquine
☐ Quinidine gluconate ☐ Quinine dihydrochloride ☐ Sulfadoxine-pyrimethamine ☐ Tetracycline ☐ Other
Date started: __/__/__
Dose: __________

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Date started: __/__/__
Dose: __________

Unit: ☐ mg ☐ ml ☐ IU # of days: ______	Unit: ☐ mg ☐ ml ☐ IU # of days: ______	Unit: ☐ mg ☐ ml ☐ IU # of days: ______
# of times a day: ______ Route: ______	# of times a day: ______ Route: ______	# of times a day: ______ Route: ______
Antibiotic: ☐ Artemether ☐ Artesunate ☐ Chloroquine ☐ Doxycycline ☐ Lumefantrine ☐ Mefloquine ☐ Quinidine gluconate ☐ Quinine dihydrochloride ☐ Sulfadoxine-pyrimethamine ☐ Tetracycline ☐ Other	Antibiotic: ☐ Artemether ☐ Artesunate ☐ Chloroquine ☐ Doxycycline ☐ Lumefantrine ☐ Mefloquine ☐ Quinidine gluconate ☐ Quinine dihydrochloride ☐ Sulfadoxine-pyrimethamine ☐ Tetracycline ☐ Other	Antibiotic: ☐ Artemether ☐ Artesunate ☐ Chloroquine ☐ Doxycycline ☐ Lumefantrine ☐ Mefloquine ☐ Quinidine gluconate ☐ Quinine dihydrochloride ☐ Sulfadoxine-pyrimethamine ☐ Tetracycline ☐ Other
Date started: ___/___/___	Date started: ___/___/___	Date started: ___/___/___
Dose: ______	Dose: ______	Dose: ______
Unit: ☐ mg ☐ ml ☐ IU # of days: ______	Unit: ☐ mg ☐ ml ☐ IU # of days: ______	Unit: ☐ mg ☐ ml ☐ IU # of days: ______
# of times a day: ______ Route: ______	# of times a day: ______ Route: ______	# of times a day: ______ Route: ______
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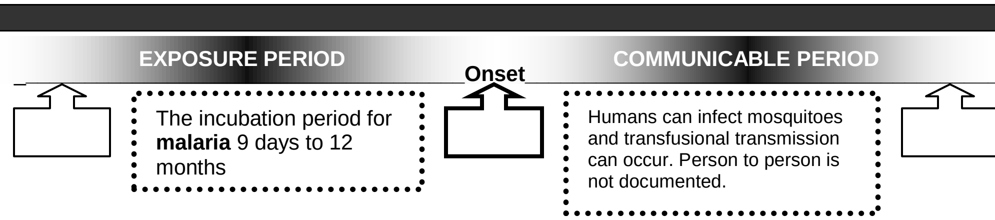
Date started: ___/___/___	Date started: ___/___/___	Date started: ___/___/___
Dose: ______	Dose: ______	Dose: ______
Unit: ☐ mg ☐ ml ☐ IU # of days: ______	Unit: ☐ mg ☐ ml ☐ IU # of days: ______	Unit: ☐ mg ☐ ml ☐ IU # of days: ______
# of times a day: ______ Route: ______	# of times a day: ______ Route: ______	# of times a day: ______ Route: ______

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Risk Factors/Travel Information – *In the 12 months prior to onset of symptoms*

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ______ City: ______ Departure date: ___/___/___ Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: Departure date: ___/___/___ Return date: ___/___/___

Received blood/blood products: ☐ Yes ☐ No ☐ Unk Date(s) received: ___/___/___

Received organ transplant: ☐ Yes ☐ No ☐ Unk Date received: ___/___/___

Organ type: ☐ Cornea ☐ Heart ☐ Kidney ☐ Other ______

Malaria in the past 12 months: ☐ Yes ☐ No ☐ Unk Malaria type: ☐ Falciparum ☐ Malariae ☐ Ovale ☐ Vivax

From date: ___/___/___ To date: ___/___/___

NOTES: