



MALARIA CASE SURVEILLANCE REPORT

Department of Health and Human Services, Centers for Disease Control and Prevention
Division of Parasitic Diseases and Malaria (MS A-06), 1600 Clifton Road, N.E. Atlanta, Georgia 30333

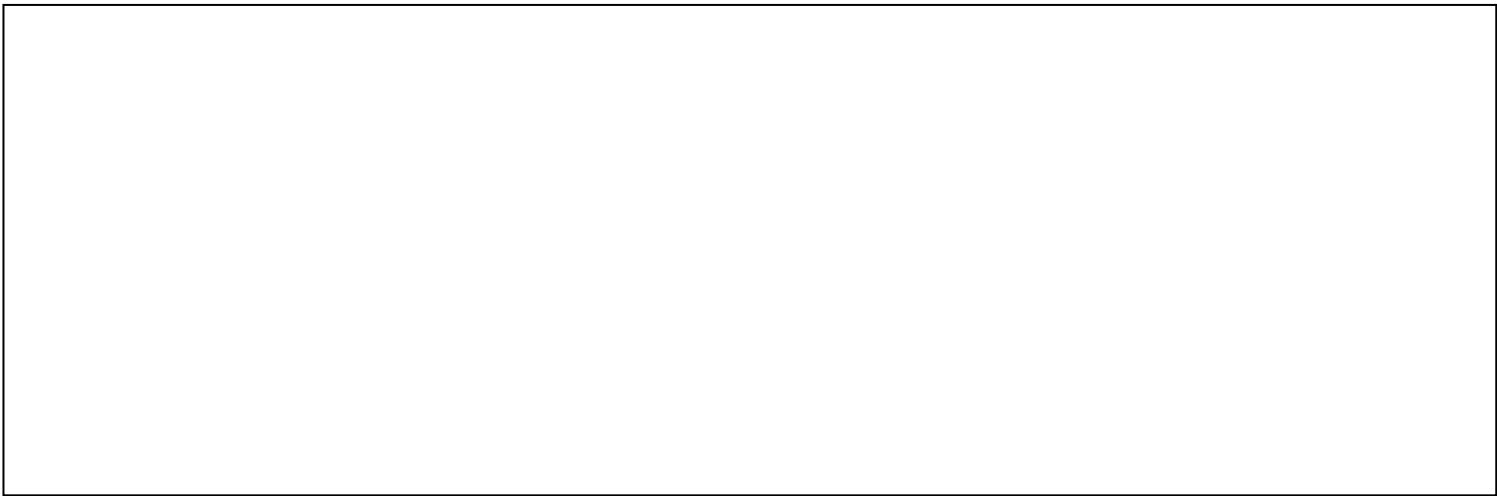


Part I

State Case No: CSID No: Case No:

Patient name (last, first):		Age: _____ yrs. mos. wks. days (circle units)		Sex:	
Date of symptom onset of this attack (mm/dd/yyyy): ____/____/____		Date of Birth: ____/____/____		<input type="checkbox"/> Male	
Physician name (last, first):		Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Female	
Telephone Number: () _____ - _____		Height: ____ ft. and ____ in. Weight: ____ lbs.		<input type="checkbox"/> Unknown	
Positive lab test result (check all that apply):		Ethnicity:		Race (select one or more):	
<input type="checkbox"/> Smear <input type="checkbox"/> PCR <input type="checkbox"/> RDT <input type="checkbox"/> No test done/unknown		<input type="checkbox"/> Hispanic or Latino		<input type="checkbox"/> American Indian/Alaska Native	
Species (check all that apply):		<input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> Native Hawaiian/Other Pacific Islander	
<input type="checkbox"/> Vivax <input type="checkbox"/> Falciparum <input type="checkbox"/> Malariae <input type="checkbox"/> Ovale <input type="checkbox"/> Not Determined		<input type="checkbox"/> Black or African American		<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other species (specify) _____		State/territory reporting this case: _____		County: _____	
Parasitemia (%): _____		Patient admitted to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Hospital: _____	
Laboratory name:		Date: ____/____/____		Hospital record No.: _____	
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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?			Principal reason for travel from/ to U.S. for most recent trip:		
<input type="checkbox"/> Yes			<input type="checkbox"/> Tourism <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Student/teacher		
<input type="checkbox"/> No, (specify country): _____			<input type="checkbox"/> Military <input type="checkbox"/> Airline/ship crew <input type="checkbox"/> Other: _____		
<input type="checkbox"/> Unknown			<input type="checkbox"/> Business <input type="checkbox"/> Missionary or dependent <input type="checkbox"/> Unknown		
<input type="checkbox"/> Peace Corps <input type="checkbox"/> Refugee/immigrant					
Was malaria chemoprophylaxis taken? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
If yes, which drugs were taken? <input type="checkbox"/> Chloroquine <input type="checkbox"/> Mefloquine <input type="checkbox"/> Doxycycline <input type="checkbox"/> Primaquine <input type="checkbox"/> Atovaquone/proguanil					
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown					
Was chemoprophylaxis taken as prescribed?		If doses were missed, what was the reason?		History of malaria in last 12 months (prior to this report)?	
<input type="checkbox"/> Yes, missed no doses		<input type="checkbox"/> Forgot		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<input type="checkbox"/> No, missed doses		<input type="checkbox"/> Didn't think needed		Date of previous illness: ____/____/____	
<input type="checkbox"/> Unknown		<input type="checkbox"/> Had a side effect (specify): _____		If yes, species (check all that apply):	
		<input type="checkbox"/> Was advised by others to stop		<input type="checkbox"/> Vivax <input type="checkbox"/> Falciparum <input type="checkbox"/> Malariae <input type="checkbox"/> Ovale	
		<input type="checkbox"/> Prematurely stopped taking once home		<input type="checkbox"/> Not Determined <input type="checkbox"/> Other (specify) _____	
		<input type="checkbox"/> Other (specify): _____			
		<input type="checkbox"/> Unknown			
Blood transfusion/organ transplant within last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date: ____/____/____					
Clinical Complications: <input type="checkbox"/> Cerebral malaria <input type="checkbox"/> ARDS <input type="checkbox"/> None		Was illness fatal: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<input type="checkbox"/> Renal failure <input type="checkbox"/> Severe anemia(Hb<7) <input type="checkbox"/> Other: _____		If yes, date of death: ____/____/____			
Therapy for this attack (check all that apply):					
<input type="checkbox"/> Chloroquine <input type="checkbox"/> Tetracycline <input type="checkbox"/> Doxycycline <input type="checkbox"/> Mefloquine <input type="checkbox"/> Exchange transfusion <input type="checkbox"/> Artesunate <input type="checkbox"/> Artemether/lumefantrine <input type="checkbox"/> Unknown					
<input type="checkbox"/> Primaquine <input type="checkbox"/> Quinine <input type="checkbox"/> Quinidine <input type="checkbox"/> Clindamycin <input type="checkbox"/> Atovaquone/proguanil <input type="checkbox"/> Other (specify): _____					
Person submitting report:			Telephone No. :		
Affiliation:			Date Submitted: ____/____/____		
For CDC Use Only. Classification <input type="checkbox"/> Imported <input type="checkbox"/> Induced <input type="checkbox"/> Introduced <input type="checkbox"/> Congenital <input type="checkbox"/> Cryptic					

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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 or 855-856-4713 (Fax: 404-718-4815)
- 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)

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

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

Was the medicine for malaria treatment taken as prescribed? No, doses missed Yes, no doses missed Unknown

Did all signs or symptoms of malaria resolve without any additional malaria 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

(If Yes): Event description	Relationship to treatment suspected*	Time to Onset since treatment start	Fatal?	Life-Threatening?	Other Seriousness?***
1 _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 _____	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* 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.

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