# 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: ______________ | Occupation type: ______________ |
| Job title: ______________ | Job title: ______________ |
| Facility name: ______________ | Facility name: ______________ |
| Address: ______________ | Address: ______________ |
| City ________ State: ________ | City ________ State: ________ |
| Zip code: ________ County: ________ | Zip code: ________ County: ________ |
| Phone: ( )- - Type: | Phone: ( )- - Type: |

## HOSPITALIZATIONS

**Was the case hospitalized?** ☐ Yes ☐ No ☐ Unknown

Hospital: ______________ Admission date: ___/___/___ Discharge date: ___/___/___

Days hospitalized:

## CLINICAL INFO & DIAGNOSIS

| **Symptoms:** | | | | | **Complications:** | |
|---|---|---|---|---|---|---|
| ☐ Fever | ☐ Chills | ☐ Headache | ☐ Nausea | ☐ Sweats | | ☐ Anemia |
| ☐ Anorexia | ☐ Cough | ☐ Hypoglycemia | ☐ Otitis media | ☐ Fatigue | | ☐ ARDS |
| ☐ Backache | ☐ Encephalitis | ☐ Joint pain | ☐ Photophobia | ☐ Lactic acidosis | | ☐ Cerebral malaria |
| | ☐ Fatigue | ☐ Muscle pain | ☐ Pneumonia | ☐ Shock | | ☐ Renal failure |
| | ☐ Vomiting | ☐ Sore throat | ☐ Respiratory distress | | | |

## TREATMENT

**Antibiotics prescribed?** ☐ Yes ☐ No ☐ Unknown

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

Antibiotic:
☐ Artemether ☐ Artesunate ☐ Chloroquine ☐ Doxycycline ☐ Lumefantrine ☐ Mefloquine ☐ Quinidine gluconate ☐ Quinine dihydrochloride ☐ Sulfadoxine-pyrimethamine ☐ Tetracycline ☐ Cephalosporins ☐ Fluoroquinolones ☐ Other
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☐ Tetracycline
☐ Cephalosporins
☐ Fluoroquinolones
☐ Other

Date started: ___/___/___

Dose: ________

Unit: ☐ mg ☐ ml ☐ IU # of days: ________

# 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.

EXPOSURE PERIOD

The incubation period for **malaria** 9 days to 12 months

**Onset**

COMMUNICABLE PERIOD

Humans can infect mosquitoes and transfusional transmission can occur. Person to person is not documented.

## 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: