



# MALARIA CASE SURVEILLANCE REPORT

Department of Health and Human Services, Centers for Disease Control and Prevention  
Division of Parasitic Diseases (MS F-22), 4770 Buford Highway, N.E. Atlanta, Georgia 30341

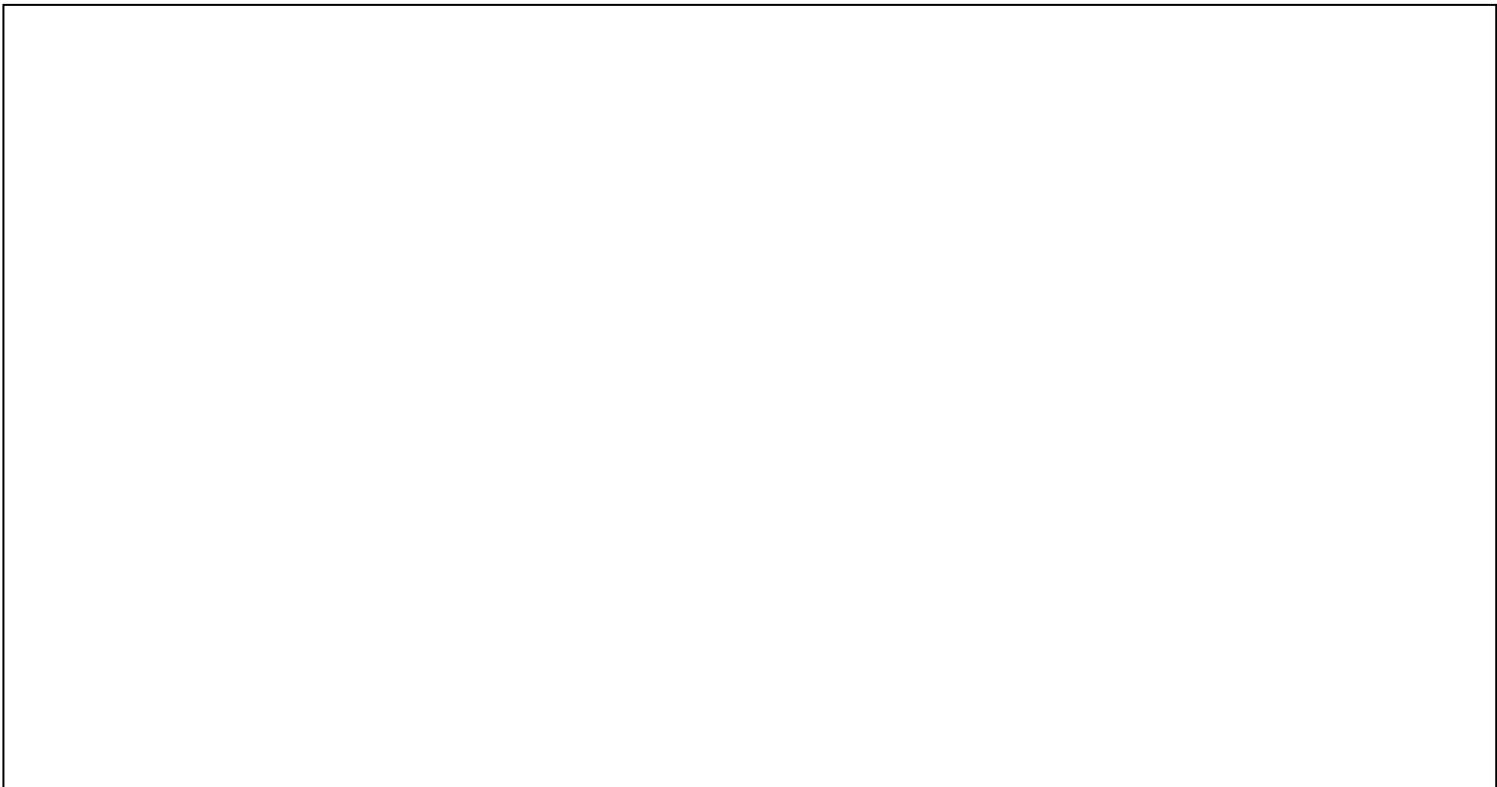


## Part I

State Case No: ..... CSID No..... Case No: .....

Patient name (last, first):	Age: _____ yrs. mos. wks. days (circle units)      Sex: _____ Date of Birth: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of symptom onset of <b>this</b> attack (mm/dd/yyyy): ____/____/____	Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Height: ____ ft. and ____ in.    Weight: ____ lbs. <input type="checkbox"/> Unknown
Physician name (last, first):	Ethnicity: _____      Race (select one or more): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Unknown
Telephone Number: (        ) _____ - _____	State/territory reporting this case: _____ County: _____
<b>Positive</b> lab test result (check all that apply): <input type="checkbox"/> Smear <input type="checkbox"/> PCR <input type="checkbox"/> RDT <input type="checkbox"/> No test done/unknown	Patient admitted to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Hospital: _____ Date: ____/____/____    Hospital record No.: _____
Species (check all that apply): <input type="checkbox"/> Vivax <input type="checkbox"/> Falciparum <input type="checkbox"/> Malariae <input type="checkbox"/> Ovale <input type="checkbox"/> Not Determined <input type="checkbox"/> Other species (specify) _____	Parasitemia (%): _____
Laboratory name:	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? <input type="checkbox"/> Yes <input type="checkbox"/> No, (specify country): _____ <input type="checkbox"/> Unknown	Principal reason for travel from/ to U.S. for most recent trip: <input type="checkbox"/> Tourism <input type="checkbox"/> Visiting friends/relatives <input type="checkbox"/> Student/teacher <input type="checkbox"/> Military <input type="checkbox"/> Airline/ship crew <input type="checkbox"/> Other: _____ <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? <input type="checkbox"/> Yes, missed no doses <input type="checkbox"/> No, missed doses <input type="checkbox"/> Unknown	If doses were missed, what was the reason? <input type="checkbox"/> Forgot <input type="checkbox"/> Didn't think needed <input type="checkbox"/> Had a side effect (specify): _____ <input type="checkbox"/> Was advised by others to stop <input type="checkbox"/> Prematurely stopped taking once home <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
History of malaria in last 12 months (prior to this report)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of previous illness: ____/____/____ If yes, species (check all that apply): <input type="checkbox"/> Vivax <input type="checkbox"/> Falciparum <input type="checkbox"/> Malariae <input type="checkbox"/> Ovale <input type="checkbox"/> Not Determined <input type="checkbox"/> Other (specify) _____	
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 <input type="checkbox"/> Renal failure <input type="checkbox"/> Severe anemia(Hb<7) <input type="checkbox"/> Other: _____	Was illness fatal: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 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	

Public reporting burden of this collection of information is estimated to average 15 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 (0920-0009).



**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 (Fax: 770-488-4206)

- 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