TEXAS Health and Human Services | Texas Department of State Health Services

Malaria Case Investigation

NBS Patient ID: _____

PLEASE PRINT LEGIBLY

☐ Confirmed ☐ Suspect

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ☐ Male ☐ Female ☐ Unknown

Street Address: _____ City, State, Zip: _____

Patient Phone: _____ Residence County: _____ Residence Country: _____

Note: If patient does not usually reside in the U.S., report case by jurisdiction of diagnosis location.

Race: ☐ American Indian/Alaskan Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Unknown ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Clinical Information

Physician: _____ Address: _____

City, State, Zip: _____ Phone: _____ Fax: _____

Was the patient hospitalized for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, provide name and location of hospital: _____

Dates of hospitalization: Admission ____/____/_____ Discharge ____/____/_____

Date of illness onset of **this** attack: ____/____/_____

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown ☐ N/A

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

If yes, provide date of death: ____/____/_____ (*submit documentation*)

Clinical Complications

Did the patient experience any clinical complications associated with severe malaria (usually parasitemia ≥ 5%)? ☐ Yes ☐ No ☐ Unknown

If yes, select all that apply and **provide supportive medical record evidence:**

☐ ARDS ☐ Renal failure ☐ Other (may include jaundice, circulatory collapse/shock): _____
☐ Cerebral malaria (severe neurological presentation) ☐ Severe anemia (Hb<7)

Laboratory Findings – submit lab report(s) with investigation if not in NEDSS

Test (Blood Smear, PCR, RDT, Other)	Date Collected	Result	Species (and parasitemia % if applicable)
	___/___/_____		
	___/___/_____		
	___/___/_____		
	___/___/_____		

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Epidemiology

Has the patient traveled or lived outside the U.S. during the past 2 years? ☐ Yes ☐ No ☐ Unknown

If yes, provide dates and locations in travel history section below.

Did the patient reside in the U.S. prior to most recent travel? ☐ Yes ☐ No ☐ Unknown

If no, specify country: _____

Principal reason for travel from/to the U.S. for most recent trip:

☐ Airline/ship crew ☐ Business ☐ Medical relief/response ☐ Military
☐ Missionary or dependent ☐ Peace Corps ☐ Refugee/immigrant ☐ Student/teacher
☐ Tourism ☐ Visiting friends/relatives ☐ Other: _____ ☐ Unknown

Travel History: International Destination/Residence Prior to Illness Onset

Country	Dates of Travel (exact if possible)
	___/___/_____ to ___/___/_____
	___/___/_____ to ___/___/_____
	___/___/_____ to ___/___/_____
	___/___/_____ to ___/___/_____

On what date did the patient return (or arrive) to the U.S. from most recent travel? _____/_____/_____

Did the patient take chemoprophylaxis for malaria (during travel period)? ☐ Yes ☐ No ☐ Unknown

If yes, which preventive drug(s) were taken? (select all that apply)

☐ Arakoda (Tafenoquine) ☐ Atovaquone/proguanil (Malarone) ☐ Chloroquine
☐ Doxycycline ☐ Hydroxychloroquine ☐ Mefloquine
☐ Primaquine ☐ Other: _____ ☐ Unknown

Was chemoprophylaxis taken as prescribed (missed no doses)? ☐ Yes ☐ No ☐ Unknown

If **no**, what was the primary reason?

☐ Didn't think needed ☐ Forgot ☐ Prematurely stopped once home ☐ Was advised by others to stop
☐ Had a side effect (specify): _____
☐ Other: _____ ☐ Unknown

Has the patient had a malaria diagnosis within the prior 12 months? ☐ Yes ☐ No ☐ Unknown

If yes, specify **species** (check all that apply):

☐ *P. falciparum* ☐ *P. malariae* ☐ *Not determined*
☐ *P. ovale* ☐ *P. vivax* ☐ *Other:* _____

Date of previous illness: ___/___/_____

In the 12 months prior to onset, did the patient receive a blood transfusion or organ transplant? ☐ Yes ☐ No ☐ Unknown

If yes, date of transfusion/transplant: ___/___/_____

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Treatment

Did the patient receive treatment for this illness after onset of symptoms? ☐ Yes ☐ No ☐ Unknown

If yes, select all that apply:

☐ Arakoda (Tafenoquine)
☐ Artemether/lumefantrine (Coartem)
☐ Artesunate
☐ Atovaquone/proguanil (Malarone)
☐ Chloroquine
☐ Clindamycin
☐ Doxycycline
☐ Exchange transfusion
☐ Hydroxychloroquine
☐ Krintafel (Tafenoquine)
☐ Mefloquine
☐ Primaquine
☐ Quinine
☐ Other: _____
☐ Unknown

Optional (NOT required follow up, only complete if available)

Please provide information regarding post-treatment clinical status (4 weeks after treatment, if treatment was provided):

Did all signs or symptoms of malaria resolve without any additional malaria treatment within 7 days after treatment start date? ☐ Yes ☐ No ☐ Unknown

If yes, did the patient experience a recurrence of signs or symptoms of malaria within the 4 weeks after starting malaria treatment? ☐ Yes ☐ No ☐ Unknown

Did patient experience any adverse events within 4 weeks after receiving malaria treatment? ☐ Yes ☐ No ☐ Unknown

If **yes**, please contact ZCB to discuss if additional details are needed. ☐ Yes ☐ No ☐ Unknown

Comments or Other Pertinent Epidemiological Data:

Case Classification

Date First Reported: ____/____/_____ Investigation: Started ____/____/_____ Completed ____/____/_____

Reporting Facility: _____

Name of Investigator: _____ (Please print clearly)

Agency: _____ (Please do not abbreviate)

Phone: _____ E-Mail: _____