

MALARIA INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ___/___/_____ Age: _____ years months Current Sex: Female Male Unknown

Is the patient deceased? No Unknown Yes Date of Death: ___/___/_____

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (____)-____-____ Cell Phone: (____)-____-____ Work Phone: (____)-____-____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

INVESTIGATION SUMMARY

Investigation Start Date: ___/___/_____ Investigation Status: Open Closed Investigator: _____

REPORTING SOURCE

Date of Report: ___/___/_____ Reporting Source: _____

CLINICAL

Physician's Name: _____ Phone Number: (____)-____-____ Ext. _____

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name: _____

Admission Date: ___/___/_____ Discharge Date: ___/___/_____ Duration of Stay _____ day(s)

Diagnosis Date: ___/___/_____ Illness Onset Date: ___/___/_____ Illness End Date: ___/___/_____

Age at Onset: _____ days hours minutes months unknown weeks years

Did the patient die from this illness? No Unknown Yes Date of Death: ___/___/_____

EPIDEMIOLOGIC

Where was the disease acquired? Indigenous within jurisdiction Out of Country Out of jurisdiction, from another jurisdiction
Out of State Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: Confirmed Not a Case Probable Suspect Unknown MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments: _____

PHA4 SUPERVISOR REVIEW

Date Due: ___/___/_____ Investigation ready for supervisor review: Reviewed (Complete) Reviewed (Incomplete)

Date investigation ready for supervisor review: ___/___/_____ Reviewed (Not a case) Yes

Review comments (completed by supervisor): _____

CONTACT ATTEMPTS

Physician Contact Date(s):

1st Attempt: ___/___/_____ 2nd Attempt: ___/___/_____ 3rd Attempt: ___/___/_____

Patient Contact Date(s):

1st Attempt: ___/___/_____ Time: _____ AM PM 2nd Attempt: ___/___/_____ Time: _____ AM PM3rd Attempt: ___/___/_____ Time: _____ AM PM

Regular Letter Mailed: ___/___/_____ Certified Letter Mailed: ___/___/_____

Was clinical information obtained from the physician or patient? Yes No**LABORATORY**Positive lab result (select all that apply): Smear PCR RDT No test done/unknownMalaria Species (select all that apply): Falciparum Malariae Not Determined Other species: _____ Ovale Vivax

Parasitemia: _____%

Specimens sent to CDC: No Unknown Yes If yes: Smears Whole Blood Other: _____**TRAVEL HISTORY**Did the patient live or travel outside the United States (US) during the past 2 years? No Unknown YesDestination 1 Type: Domestic State/Territory: _____ International Country: _____Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/_____ Departure Date: ___/___/_____Destination 2 Type: Domestic State/Territory: _____ International Country: _____Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/_____ Departure Date: ___/___/_____Destination 3 Type: Domestic State/Territory: _____ International Country: _____Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/_____ Departure Date: ___/___/_____

If more than 3 destinations, specify details here: _____

Did the patient reside in US prior to most recent travel? No Unknown Yes

Principal reason for travel from/to US for most recent trip:

Airline/ship crew Military Peace Corps Refugee/immigrant Tourism Visiting friends/relatives
Business Missionary or dependent Other: _____ Student/teacher Unknown**NON-TRAVEL RISK FACTORS**Has patient had Malaria in last 12 months prior to this report? No Unknown Yes Date of previous illness: ___/___/_____If yes, (select all that apply): Falciparum Malariae Not Determined Other species: _____ Ovale VivaxBlood transfusion/organ transplant within last 12 months? Yes No Unknown Transfusion/transplant date: ___/___/_____**MALARIA CHEMOPROPHYLAXIS**Height: _____ feet _____ inches Weight: _____ pounds Was malaria chemoprophylaxis taken? No Unknown Yes

If yes, which drugs were taken?

Atovaquone/proguanil Chloroquine Doxycycline Mefloquine Other: _____ Primaquine UnknownWas chemoprophylaxis taken as prescribed? No (missed doses) Unknown Yes (no missed doses)

If doses were missed, what was the reason?

Didn't think needed Had a side effect: _____ Prematurely stopped taking once home Was advised by others to stop
Forgot Other: _____ Unknown**CLINICAL COMPLICATIONS**Clinical Complications: ARDS Cerebral Malaria None Other: _____ Renal failure Severe anemia (Hb < 7)

Therapy for this attack (select all that apply):

Artesunate Clindamycin Exchange transfusion Primaquine Tetracycline
Artemether/lumefantrine Chloroquine Mefloquine Quinidine Unknown
Atovaquone/proguanil Doxycycline Other: _____ Quinine

FOLLOW UP (COMPLETE 4 WEEKS POST-TREATMENT)

List all prescription and over the counter medicines patient took during **2 weeks** before starting malaria treatment:

List all prescription and over the counter medicines patient took during **4 weeks** after starting malaria treatment:

Was malaria treatment taken as prescribed? No (missed doses) Unknown Yes (no missed doses)

Did all signs and symptoms of malaria resolve within **7 days** of initiating malaria treatment? Yes No Unknown

If yes, did patient experience recurrence of malaria signs or symptoms during **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, specify event:

Event 1: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? Yes No Unknown Outcome: Fatal Life-threatening Serious[†]

Event 2: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? Yes No Unknown Outcome: Fatal Life-threatening Serious[†]

Event 3: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? Yes No Unknown Outcome: Fatal Life-threatening Serious[†]

Event 4: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? Yes No Unknown Outcome: Fatal Life-threatening Serious[†]

Event 5: _____ Time since onset of malaria treatment: _____

Suspect relationship to malaria treatment? Yes No Unknown Outcome: Fatal Life-threatening Serious[†]

[†]Serious adverse event: *persistent or significant disability/incapacity, congenital anomaly/birth defect, medically significant (i.e., jeopardizes patient or may require medical/surgical intervention), or requires inpatient hospitalization.*