MALARIA INVESTIGATION WORKSHEET

MR #: _____ **CDRSS #:** _____

DEMOGRAPHICS

Patient Last Name **First Name**	**DOB:** ____ / ____ / ____	**Phone number**
Address	**City**	**Municipality**

Race

☐ White ☐ Black ☐ American Indian or Alaskan Native
☐ Asian ☐ Pacific Islander ☐ Unknown

Ethnicity

◯ Hispanic
◯ Non-Hispanic ◯ Unknown

Country of Birth	**Sex** ☐Male ☐Female	**Industry (work setting)**	**Occupation (job title)**

CLINICAL INFORMATION

Pregnancy Status

◯ Pregnant
◯ Not Pregnant ◯ Unknown

Onset Date ____ / ____ / ____

Diagnosis:

Signs/Symptoms	Response	Onset Date
Abdominal pain/cramps	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Altered mental status	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Anemia	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Asymptomatic	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Cerebral malaria	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Chills	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Fever, Tmax:_____F	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Headache	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Jaundice	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Myalgia	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Neurological disorders	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Respiratory distress	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Sweats	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Vomiting	◯ Yes ◯ No ◯ Unk.	____ / ____ / ____
Other *specify*:		____ / ____ / ____

Was patient hospitalized because of this illness?

◯ Yes, *specify location and date(s)*

Hospital name: _____

Admission: ____ / ____ / ____ Discharge: ____ / ____ / ____

Diagnosis:_____

◯ No

Did the patient die because of this illness?

◯ Yes,
Date ____ / ____ / _____

◯ No

◯ Unknown

RISK FACTORS AND ADDITIONAL REQUIREMENTS	Response
In the 30 days prior to illness onset or diagnosis, did the patient donate blood? *If Yes, Date of blood donation:* _____ *Location of blood donation:* _____	◯ Yes ◯ No ◯ Unk.
In the 30 days before illness onset/diagnosis, did the patient donate an organ? *Organ type:* *Date of donation:* *Facility:*	◯ Yes ◯ No ◯ Unk.
Did the patient have close contact with a confirmed/probable case?	◯ Yes ◯ No ◯ Unk.
In the 12 months prior to illness onset/diagnosis, did the patient receive a blood transfusion? *If yes, provide a list of all transfusion date(s), hospital where transfused, type of blood product(s), and source of blood products:*	◯ Yes ◯ No ◯ Unk.
In the 30 days to illness onset/diagnosis, did the patient receive an organ transplant? *If yes, list type of organ, date, hospital:*	◯ Yes ◯ No ◯ Unk.
In the 2 years before illness onset or diagnosis, did the patient travel outside the country? *If yes, specify ALL locations and dates of travel:* *Reason for travel:* ☐ *Visiting friends/relatives* ☐ *Student/teacher* ☐ *Military* ☐ *Airline/ship crew* ☐ *Business* ☐ *Missionary or dependent* ☐ *Peace corps* ☐ *Refugee/immigrant* ☐ *Other:*_____ ☐ *Unknown* ☐ *Not asked* **Did the patient take chemoprophylaxis to prevent malaria while traveling?** *Specify medication:* _____	◯ Yes ◯ No ◯ Unk. ◯ Yes ◯ No ◯ Unk.
In the 2 years prior to illness onset or diagnosis, did the patient relocate to the US from a country with known disease transmission? *If yes, specify country:* *Date of relocation:* _____ /_____ /_____	◯ Yes ◯ No ◯ Unk.
In the past 12 months, was the patient previously diagnsed with malaria?	◯ Yes ◯ No ◯ Unk.

TREATMENT INFORMATION

Treatment	Dosage	Dates
☐ Artemether-lumefantrine (Coartem)		_____ / _____ / _____ to _____ / _____ / _____
☐ Atovaquone/proguanil (Malarone)		_____ / _____ / _____ to _____ / _____ / _____
☐ Azithromycin		_____ / _____ / _____ to _____ / _____ / _____
☐ Clindamycin		_____ / _____ / _____ to _____ / _____ / _____
☐ Doxycycline		_____ / _____ / _____ to _____ / _____ / _____

☐ Chloroquine (or hydroxychloroquine)		_____ / _____ / _____ to _____ / _____ / _____
☐ Exchange transfusion		_____ / _____ / _____ to _____ / _____ / _____
☐ Mefloquine Hydrochloride		_____ / _____ / _____ to _____ / _____ / _____
☐ Primaquine		_____ / _____ / _____ to _____ / _____ / _____
☐ Quinine sulfate		_____ / _____ / _____ to _____ / _____ / _____
☐ Tafenoquine		_____ / _____ / _____ to _____ / _____ / _____
☐ Tetracycline		_____ / _____ / _____ to _____ / _____ / _____
Other: _____		_____ / _____ / _____ to _____ / _____ / _____
Other: _____		_____ / _____ / _____ to _____ / _____ / _____
☐ Not treated		

LABORATORY TESTING

Was a blood smear performed? ◯ Yes ◯ No ◯ Unk.

If Yes, Specimen collection date: _____ Parasetemia: _____

Which *Plasmodium species* is the cause of illness?

☐ *P. falciparum* ☐ *P. vivax* ☐ *P. ovale* ☐ *P. malariae* ☐ *P. knowlesi*

☐ Unknown ☐ Speciation not performed

ADDITIONAL NOTES