

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

MALARIA CASE REPORT

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence		Apartment/Unit Number		Ethnicity (check one)	
City/Town		State	Zip Code	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unk	
Census Tract	County of Residence		Country of Residence		
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone/Pager		Work/School Telephone	
E-mail Address		Other Electronic Contact Information			
Work/School Location		Work/School Contact			
Gender					
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		Patient's Parent/Guardian Name			
Occupation Setting (see list on page 6)		Other Describe/Specify			
Occupation (see list on page 6)		Other Describe/Specify			
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

First three letters of
patient's last name:

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SIGNS AND SYMPTOMS						
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)			Date First Sought Medical Care (mm/dd/yyyy)	
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted		
Fever				Highest temperature (specify °F/°C)		
Headache						
Abdominal pain						
Chills						
Sweats						
Myalgia						
Other signs / symptoms (specify)						
PAST MEDICAL HISTORY						
Has the patient previously been diagnosed with malaria? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Previous Diagnosis <input type="checkbox"/> P. falciparum <input type="checkbox"/> P. malariae <input type="checkbox"/> Not Determined <input type="checkbox"/> P. vivax <input type="checkbox"/> P. ovale <input type="checkbox"/> Unknown			Date of Previous Illness (mm/dd/yyyy)	
Did the patient have a blood transfusion or transplant within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				If Yes, specify		
CLINICAL COMPLICATIONS FOR THIS ATTACK						
Cerebral malaria? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify				
Spleen rupture? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify				
ARDS pulmonary edema? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify				
Anemia (Hb<11, Hct<33)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, specify				
HOSPITALIZATION						
Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, how many total hospital nights?	
If there were any ER or hospital stays related to this illness, specify details below.						
HOSPITALIZATION - DETAILS						
Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)		
	City			Discharge / Transfer Date (mm/dd/yyyy)		
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis	
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)		
	City			Discharge / Transfer Date (mm/dd/yyyy)		
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis	

First three letters of
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OUTCOME		
Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
TREATMENT / MANAGEMENT		
Received treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Therapy for this attack <input type="checkbox"/> Chloroquine <input type="checkbox"/> Primaquine <input type="checkbox"/> Pyrimethamine-sulfadoxine <input type="checkbox"/> Unk <input type="checkbox"/> Mefloquine <input type="checkbox"/> Atovaquone-proguanil (Malarone™) <input type="checkbox"/> Exchange transfusion <input type="checkbox"/> Tetracycline/doxycycline <input type="checkbox"/> Quinine/quinidine <input type="checkbox"/> Other: _____	
MALARIA CHEMOPROPHYLAXIS		
Was malaria chemoprophylaxis taken? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Drugs Taken <input type="checkbox"/> Chloroquine <input type="checkbox"/> Doxycycline <input type="checkbox"/> Atovaquone-proguanil (Malarone™) <input type="checkbox"/> Mefloquine <input type="checkbox"/> Primaquine <input type="checkbox"/> Other (specify): _____	
Were all pills taken as prescribed? <input type="checkbox"/> Yes, missed no doses <input type="checkbox"/> No, missed one to few doses <input type="checkbox"/> No, missed more than a few, but less than half of the doses <input type="checkbox"/> No, missed half or more of the doses <input type="checkbox"/> Don't know <input type="checkbox"/> Other (specify): _____	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 <input type="checkbox"/> Was advised by others to stop <input type="checkbox"/> Prematurely stopped taking once home	If had a side effect, specify
LABORATORY INFORMATION		
LABORATORY RESULTS SUMMARY		
Microscopy of Blood Smear <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unk	If Positive, specify <input type="checkbox"/> P. falciparum <input type="checkbox"/> P. vivax <input type="checkbox"/> P. malariae <input type="checkbox"/> P. ovale <input type="checkbox"/> Not determined <input type="checkbox"/> Unk Collection Date (mm/dd/yyyy) Laboratory Name Telephone Number	
PCR of Blood <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unk	If Positive, specify <input type="checkbox"/> P. falciparum <input type="checkbox"/> P. vivax <input type="checkbox"/> P. malariae <input type="checkbox"/> P. ovale <input type="checkbox"/> Not determined <input type="checkbox"/> Unk Collection Date (mm/dd/yyyy) Laboratory Name Telephone Number	
Rapid Diagnostic Test (RDT) <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done <input type="checkbox"/> Unk	If Positive, specify <input type="checkbox"/> P. falciparum <input type="checkbox"/> P. vivax, malariae, or ovale <input type="checkbox"/> Mixed infection (P. falciparum and P. vivax, malariae, or ovale) Specify RDT <input type="checkbox"/> BinaxNOW™ <input type="checkbox"/> Other (specify): _____ Collection Date (mm/dd/yyyy) Laboratory Name Telephone Number	
EPIDEMIOLOGIC INFORMATION		
TRAVEL HISTORY		
Did patient travel out of county of residence during the three months prior to illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If No, did patient travel out of county of residence during the three years prior to illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
If Yes for one of these questions, answer the following two questions, and specify all locations and dates in the Travel History - Details table (see on page 4).		
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"/> Refugee/immigrant <input type="checkbox"/> Military <input type="checkbox"/> Airlines/ship crew <input type="checkbox"/> Student/teacher <input type="checkbox"/> Peace Corps <input type="checkbox"/> Missionary or dependent <input type="checkbox"/> Other: _____	Did patient reside in U.S. prior to most recent travel? <input type="checkbox"/> Yes, for > 12 months <input type="checkbox"/> Yes, for < 12 months <input type="checkbox"/> Unk <input type="checkbox"/> No, specify country: _____	

First three letters of
patient's last name:

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TRAVEL HISTORY - DETAILS			
Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)	
NOTES / REMARKS			
REPORTING AGENCY			
Investigator Name	Local Health Jurisdiction	Telephone Number	Date (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			
EPIDEMIOLOGICAL LINKAGE			
Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number		
DISEASE CASE CLASSIFICATION			
Case Classification (see case definition below) <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspect			
STATE USE ONLY			
State Case Classification <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information			
CASE DEFINITION			
MALARIA (2010)			
CLINICAL DESCRIPTION			
The first symptoms of malaria (most often fever, chills, sweats, headaches, muscle pains, nausea, and vomiting) are often not specific and are also found in other diseases (such as influenza and other common viral infections). Likewise, the physical findings are often not specific (elevated temperature, perspiration, tiredness). In severe malaria (caused by <i>P. falciparum</i>), clinical findings (confusion, coma, neurologic focal signs, severe anemia, respiratory difficulties) are more striking and may increase the suspicion index for malaria.			
LABORATORY CRITERIA FOR DIAGNOSIS CASE			
<ul style="list-style-type: none"> • Detection of circulating malaria-specific antigens using rapid diagnostic test (RDT), OR • Detection of species specific parasite DNA in a sample of peripheral blood using a Polymerase Chain Reaction test*, OR • Detection of malaria parasites in thick or thin peripheral blood films. 			
CASE CLASSIFICATION:			
Suspected:			
<ul style="list-style-type: none"> • Detection of Plasmodium species by rapid diagnostic antigen testing without confirmation by microscopy or nucleic acid testing in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country. 			

(continued on page 5)

CASE DEFINITION (continued)**Confirmed:**

- Detection and specific identification of malaria parasites by microscopy on blood films in a laboratory with appropriate expertise in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country, OR
- Detection of *Plasmodium* species by nucleic acid test* in any person (symptomatic or asymptomatic) diagnosed in the United States, regardless of whether the person experienced previous episodes of malaria while outside the country.

COMMENT

* Laboratory-developed malaria PCR tests must fulfill CLIA requirements, including validation studies

A subsequent attack experienced by the same person but caused by a different *Plasmodium* species is counted as an additional case. A subsequent attack experienced by the same person and caused by the same species in the United States may indicate a relapsing infection or treatment failure caused by drug resistance or a separate attack.

Blood smears from questionable cases should be referred to the CDC Division of Parasitic Diseases Diagnostic Laboratory for confirmation of the diagnosis.

Cases also are classified according to the following World Health Organization categories:

- *Autochthonous*:
 - Indigenous*: malaria acquired by mosquito transmission in an area where malaria is a regular occurrence
 - Introduced*: malaria acquired by mosquito transmission from an imported case in an area where malaria is not a regular occurrence
- *Imported*: malaria acquired outside a specific area (e.g., the United States and its territories)
- *Induced*: malaria acquired through artificial means (e.g., blood transfusion, common syringes, or malariotherapy)
- *Relapsing*: renewed manifestation (i.e., of clinical symptoms and/or parasitemia) of malarial infection that is separated from previous manifestations of the same infection by an interval greater than any interval resulting from the normal periodicity of the paroxysms
- *Cryptic*: an isolated case of malaria that cannot be epidemiologically linked to additional cases

Source: http://www.cdc.gov/ncphi/diss/nndss/casedef/malaria_current.htm

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare/Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor/actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory/seasonal worker • Agriculture - other/unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other/unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other/unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other/unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent/guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other/unknown • Teacher/employee - preschool or kindergarten • Teacher/employee - elementary or middle school • Teacher/employee - high school • Teacher/instructor/employee - college or university • Teacher/instructor/employee - other/unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other/unknown • Volunteer • Other • Refused • Unknown