Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Malaria

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y N DK NA
☐ ☐ ☐ ☐ Fever Highest measured temp: _____ °F
Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐ ☐ ☐ ☐ Recurring fever
Number of attacks: _____
Days between attacks: _____
☐ ☐ ☐ ☐ Chills
☐ ☐ ☐ ☐ Sweats
☐ ☐ ☐ ☐ Headache

Hospitalization

Y N DK NA
☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y N DK NA
☐ ☐ ☐ ☐ Died from illness Death date ___/___/___
☐ ☐ ☐ ☐ Autopsy

Predisposing Conditions

Y N DK NA
☐ ☐ ☐ ☐ Malaria in past 12 months (prior to this report)
Date of prior malaria illness ___/___/___
Prior malaria species: _____
☐ ☐ ☐ ☐ Pregnant
Estimated delivery date ___/___/___
OB name, address, phone: _____
_____
_____
_____

Laboratory

Collection date ___/___/___

Y N DK NA
☐ ☐ ☐ ☐ Anemia (Hb<11, Hct<33)
☐ ☐ ☐ ☐ **Malaria parasites demonstrated (blood films)**

Clinical Findings

Y N DK NA
☐ ☐ ☐ ☐ Cerebral malaria
☐ ☐ ☐ ☐ Kidney (renal) abnormality or failure
☐ ☐ ☐ ☐ Liver abnormality or failure
☐ ☐ ☐ ☐ Adult Respiratory Distress Syndrome (ARDS)
☐ ☐ ☐ ☐ Complications
Specify: _____

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count backward to determine probable exposure period

	Exposure period*		onset
Days from onset:	-30	-7	
Calendar dates:			

* Infection by blood transfusion may result in longer incubation periods (up to 2 months). For some strains of *P. vivax,* there may be a protracted incubation period of 8 to 10 months.

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Dates/Locations: _____
_____
_____

Y N DK NA

☐ ☐ ☐ ☐ Case knows anyone with similar symptoms

Y N DK NA

☐ ☐ ☐ ☐ In area with mosquito activity
Date/Location: _____
Remember mosquito bite ☐**Y** ☐**N** ☐**DK** ☐**NA**
Date/Location: _____

☐ ☐ ☐ ☐ Any medical or dental procedure
Blood transfusion or blood products (e.g. IG, factor concentrates)
Date of receipt: __/__/__

☐ ☐ ☐ ☐ Organ or tissue transplant recipient
Date of receipt:__/__/__

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

☐ ☐ ☐ ☐ Malaria chemoprophylaxis taken
Specify type: _____
Were all pills taken as prescribed?
☐ Yes, missed no doses
☐ No, missed one to a few doses
☐ No, missed more than a few but < half of doses
☐ No, missed half or more of doses
☐ No, missed doses but not sure how many
☐ Unknown

Reasons for missed doses:
☐ Forgot ☐ Didn't think needed
☐ Had side effect (specify below)
☐ Advised by others to stop
☐ Prematurely stopped taking once home
☐ Other (specify below) ☐ Unk
Specify _____

Y N DK NA

☐ ☐ ☐ ☐ Antimalarial therapy for this attack
Type: _____

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
Agency and location: _____
Specify type of donation: _____

☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Notify blood or tissue bank
☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

Malaria: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered