Malaria

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Investigation Information

* indicates required fields

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	First Name*	Middle Initial

Street Address

City	County	State	Zip
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.	Report Date mm/dd/yyyy

Parent / Guardian Information

Last Name	First Name	Middle Initial	Relationship to Patient

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	County	State	Zip
		West Virginia	

Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	Age	Age Units
		○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Patient Demographic Information cont.

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native* ☐ *Asian*
☐ *Black or African American* ☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White* ☐ *Unknown*
☐ *Failure to report race/missing race* ☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms
mm/dd/yyyy

Date of diagnosis
mm/dd/yyyy

Was patient hospitalized for this disease?

○ *Yes* ○ *No* ○ *Unknown*

Name of Hospital

Date of Admission
mm/dd/yyyy

Patient outcome from this disease:

○ *Died* ○ *Survived* ○ *Unknown*

Date of Death
mm/dd/yyyy

Is patient pregnant?

○ *Yes* ○ *No* ○ *Unknown*

History of malaria in last 12 months (prior to this report)?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, species

(Check all that apply)

☐ *Vivax* ☐ *Falciparum* ☐ *Malariae* ☐ *Ovale* ☐ *Not Determined*

Date of previous illness
mm/dd/yyyy

Blood transfusion/transplant within last 12 months?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, date
mm/dd/yyyy

Clinical complications for this attack

(Check all that apply)

☐ *Cerebral Malaria* ☐ *Renal Failure* ☐ *ARDS* ☐ *Anemia (Hb<11, Hct<33)* ☐ *None* ☐ *Other (specify):*_____

Therapy for this attack

(Check all that apply)

☐ *chloroquine* ☐ *primaquine* ☐ *tetracycline/doxycycline* ☐ *quinine/quinidine*
☐ *mefloquine* ☐ *pyrimethamine-sulfadoxine* ☐ *exchange* ☐ *transfusion*
☐ *Malarone* ☐ *unknown* ☐ *other (specify):*_____

Treatment/Prophylaxis

Was malaria chemoprophylaxis taken?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, which drugs were taken?

(Check all that apply)

☐ *Chloroquine* ☐ *Mefloquine* ☐ *Doxycycline* ☐ *Primaquine* ☐ *Malarone* ☐ *Other (specify):*_____

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 the doses*
○ *No, missed half or more of the doses* ○ *No, missed doses but not sure how many* ○ *Don't know*

If doses were missed, what was the reason?

(Check all that apply)

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

Laboratory Results

Lab results:

○ *Smear Positive* ○ *Smear Negative* ○ *No Smear Taken*

Species

(Check all that apply)

☐ *Vivax* ☐ *Falciparum* ☐ *Malariae* ☐ *Ovale* ☐ *Not Determined*

Laboratory name:

Telephone number:
###-###-####

Specimens being sent to CDC?

○ *Yes* ○ *No* ○ *Unknown*

If Yes:

○ *Smears* ○ *Whole Blood* ○ *Other:*_____

Laboratory Results cont.

Laboratory Name	Phone ###-###-####	Ext.	Fax Number ###-###-####

Address

State:	Zip:
West Virginia	

Reporting Source

Last Name	First Name

Phone ###-###-####	Ext.	Fax ###-###-####

Facility

Address

City	State	Zip
	West Virginia	

E-mail

Provider with Further Patient Information

Last Name	First Name

Phone ###-###-####	Ext.	Fax ###-###-####

Address

City	State	Zip
	West Virginia	

Public Health Investigation

Name of Person Interviewed	Relationship to Patient	Date reported to public health mm/dd/yyyy

Investigator	Date public health investigation began mm/dd/yyyy	Health Department	Phone ###-###-####

Ext.	

Investigation ID	Part of an Outbreak?	Outbreak Name	Lost to follow-up?
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

○ *Check if epi-linked to another case and complete information below*

Last Name of Epi-linked Case	First Name	DOB mm/dd/yyyy

County	Onset Date mm/dd/yyyy

Epidemiologic Information

Has the patient traveled or lived outside the USA during the past 4 years?

○ *Yes* ○ *No* ○ *Unknown*

If Yes, specify:

Country	Date returned/arrived in U.S.	Duration of stay in foreign country
(select from list)	mm/dd/yyyy	(days)

Did patient reside in U.S. prior to most recent travel?

○ *Yes, for =>12 months* ○ *Yes, for <12 months* ○ *No, (specify country):* ○ *Unknown*

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

○ *Airline/Ship Crew* ○ *Business* ○ *Military* ○ *Missionary or Dependent* ○ *Peace Corps*
○ *Refugee/Immigrant* ○ *Student/Teacher* ○ *Tourism* ○ *Visiting Friends/Relatives* ○ *Other (specify)*_____

Describe public health action taken