North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

MALARIA

Confidential Communicable Disease Report—Part 2

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease?..... ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever..... ☐Y ☐N ☐U
Cerebral malaria..... ☐Y ☐N ☐U
Acute Respiratory Distress Syndrome (ARDS)..... ☐Y ☐N ☐U
Acute renal failure..... ☐Y ☐N ☐U
Anemia..... ☐Y ☐N ☐U
Hemoglobin < 11..... ☐Y ☐N ☐U
Hematocrit < 33..... ☐Y ☐N ☐U
Malaria in last 12 months (prior to this report)..... ☐Y ☐N ☐U
If yes, date of previous illness (mm/dd/yyyy):____________________
Species (check all that apply)
- ☐ Vivax
- ☐ Falciparum
- ☐ Malariae
- ☐ Ovale
- ☐ Not determined

Other symptoms, signs, clinical findings, or complications consistent with this illness..... ☐Y ☐N ☐U
If yes, specify:____________________________
Patient had no complications..... ☐Y ☐N ☐U

TREATMENT

Did patient receive therapy for this attack?..... ☐Y ☐N ☐U
Specify therapy:
- ☐ Chloroquine
- ☐ Doxycycline
- ☐ Exchange transfusion
- ☐ Malarone
- ☐ Mefloquine
- ☐ Primaquine
- ☐ Pyrimethamine-sulfadoxine
- ☐ Quinidine
- ☐ Quinine
- ☐ Tetracycline
- ☐ Other, specify:
- ☐ Unknown

Did patient receive an exchange transfusion for this attack?..... ☐Y ☐N ☐U
Was malaria chemoprophylaxis taken?..... ☐Y ☐N ☐U
If yes, which drugs were taken
- ☐ Chloroquine
- ☐ Primaquine
- ☐ Doxycycline
- ☐ Malarone
- ☐ Mefloquine
- ☐ Other
- ☐ Unknown

Were all pills taken as prescribed?
- ☐ Yes, missed no doses
- ☐ No, missed one to a few doses
- ☐ No, missed more than a few but less than half the doses
- ☐ No, missed half or more of the doses
- ☐ No, missed doses but not sure how many
- ☐ Unknown

TREATMENT (continued)

Reason(s) for missed dose(s)
- ☐ Forgot
- ☐ Didn't think needed
- ☐ Had a side effect
  Specify:____________________
- ☐ Advised by others to stop
- ☐ Prematurely stopped taking once home
- ☐ Other

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours?..... ☐Y ☐N ☐U
Hospital name: ______________________________
City, State:_________________________________
Hospital contact name: _______________________
Telephone: (______) ______ - ___________
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

CLINICAL OUTCOMES

Discharge/Final diagnosis:____________________
____
Survived?..... ☐Y ☐N ☐U
Died?..... ☐Y ☐N ☐U
Died from this illness?..... ☐Y ☐N ☐U
Date of death (mm/dd/yyyy):_____/_____/_____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ None of the above

Did patient have a travel history during the 40 days prior to onset of symptoms? .... ☐ Y ☐ N ☐ U

List travel dates and destinations _______________
____
____

Has the patient traveled or lived outside of the US during the past 4 years? .... ☐ Y ☐ N ☐ U

If yes specify country _______________________
Date returned/arrived in US (mm/dd/yyyy):_____/_____/_____
Duration of stay in foreign country ______________

Additional travel/residency information:

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

From 12 months prior to onset of symptoms, did the patient have any of the following health care exposures?

- ☐ Blood or blood products (transfusion) – recipient
  Date received:_________________
- ☐ Transplant recipient (tissue/organ/bone/bone marrow)
  Date received: _________________
- ☐ No
- ☐ Unknown

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? .... ☐ Y ☐ N ☐ U
Date of interview (mm/dd/yyyy):_____/_____/_____

Medical records reviewed (including telephone review with provider/office staff)? .... ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
City ______________________________________
County______________________________________

☐ Outside NC, but within US
City ______________________________________
State ______________________________________
County______________________________________

☐ Outside US
City ______________________________________
Country ____________________________________

☐ Unknown

Is the patient part of an outbreak of this disease? .... ☐ Y ☐ N

Notes: