MINNESOTA
MDH
DEPARTMENT OF HEALTH
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MALARIA CASE REPORT FORM

PLASMODIUM SPECIES (Mark all that apply)

☐ *P. falciparum* ☐ *P. malariae*
☐ *P. vivax* ☐ unknown
☐ *P. ovale* ☐ Other: _____

MDH only

Conf	Susp	N/C*	A/D**
☐	☐	☐	☐

* N/C: Not a Case
**A/D: Asymptomatic Blood/Organ Donor

Staff Date
☐CRF
☐Entry
☐Rev

Onset Date: _____ /_____ /_____ ☐ Onset date unknown

Reporting Date: _____ /_____ /_____

PATIENT DEMOGRAPHICS

NAME
Last: _____ First: _____ Middle: _____

DOB: _____ /_____ /_____ Age: _____ (in: ☐yrs ☐mos ☐days)

Medical Record #:

GENDER: ☐ M ☐ F ☐ Unk
Height: ___ ft. ___ in. Weight: ___ lbs

PREFERRED LANGUAGE
☐English ☐Unknown ☐Other: _____

COUNTRY OF BIRTH
☐United States ☐Unknown ☐Other: _____

ADDRESS
Street: _____ County: _____
City: _____ State: _____ Zip:_____ ☐Address unknown ☐Homeless

PHONE
home: (_____) -_____-_____
alt: (_____) -_____-_____

Occupation: _____
Parent/Guardian:_____

Ethnicity: ☐Unknown ☐Hispanic/Latino ☐Non-Hispanic/Latino

Race: (check all that apply) ☐Unknown ☐White ☐Other: _____ ☐American Indian / Alaskan Native ☐Black / African American ☐Native Hawaiian / Pacific Islander ☐Asian

HOSPITAL / CLINIC INFORMATION

	REPORTER	ORDERING PROVIDER	PRIMARY CARE PROVIDER	LAB *(complete details, p. 2)*
Name	☐Provider ☐ICP/IP ☐Lab ☐Other:			
Phone	( ) - -	( ) - -	( ) - -	( ) - -
Facility				Spec.coll. date of 1st pos. test: _____/_____/_____

Hospitalized? ☐Y ☐N ☐U Admission date: _____/_____/_____ Discharge: _____/_____/_____ Hospital: _____

Died? ☐Y ☐N ☐U Date of death: _____/_____/_____ Cause of death: _____

Pregnant? (if applic.) ☐Y ☐N ☐U Due date: _____/_____/_____

If MDH needs additional information, please contact: ☐Reporter ☐Ordering provider ☐Primary care provider ☐Lab ☐Other: _____

HEALTH HISTORY

Immune suppression: ☐Y ☐N ☐U Describe: ☐Cancer ☐Immunosuppressive medication Other: _____

Underlying illness: ☐Y ☐N ☐U Describe: _____

Blood transfusion or organ transplant < 1 year before onset? ☐Y ☐N ☐U Describe (dates, products, location, reason):_____

History of malaria in last 12 months (prior to this report)? ☐Y ☐N ☐U Describe (date of previous illness, clinical complications, therapy):_____ If yes, species: _____

CLINICAL INFORMATION

Symptomatic? ☐Y ☐N ☐U 1st office visit: _____ / _____ /_____ Where: _____

Key Signs/Symptoms	Y	N	U	
Anemia:	☐	☐	☐	Lowest RBC:_____ Hgb:_____ Hct:____
Fever:	☐	☐	☐	Max temp: _____ °F (☐temp unk)
Chills / sweats:	☐	☐	☐	
Fatigue:	☐	☐	☐	
Myalgias (muscle pain):	☐	☐	☐	

Key Signs/Symptoms *(cont.)*	Y	N	U	
Headache:	☐	☐	☐	
Confusion:	☐	☐	☐	
Coma:	☐	☐	☐	
Neurologic focal signs:	☐	☐	☐	Describe: _____
Respiratory difficulties:	☐	☐	☐	

Complications
Cerebral malaria: ☐Y ☐N ☐U
Renal Failure: ☐Y ☐N ☐U
Acute respiratory distress syndrome (ARDS): ☐Y ☐N ☐U
Organ Failure: ☐Y ☐N ☐U Organ(s):_____
Severe Anemia ☐Y ☐N ☐U
None ☐Y ☐N ☐U

Other signs/symptoms (list):

Anti-Malarial Treatment? ☐Y ☐N ☐U *(e.g. Mefloquine [Lariam], Chloroquine [Aralen], Malarone, Proguanil [Paludrine], Fansidar, Doxycycline, Primaquine)*

Type:_____ Date:_____/_____/_____ Dose/Duration:_____
Type:_____ Date:_____/_____/_____ Dose/Duration:_____

Recently donated blood, organ, or tissue? ☐Y ☐N ☐U Date, product, location:

MALARIA TESTING

Test	Collection Date	Lab Name	RESULT (Eq = Equivocal) Pos Neg Eq Unknown	If Positive: *Plasmodium* species *falciparum* *vivax* *ovale* *malariae* *Unknown* *Other (list)*
Blood Film (Smear) ☐not done	____/____/____		☐ ☐ ☐ ☐ Parasitemia (% ____	☐ ☐ ☐ ☐ ☐ ☐ _____
Blood Film (Smear) (Repeat) ☐not done	____/____/____		☐ ☐ ☐ ☐ Parasitemia (%) ____	☐ ☐ ☐ ☐ ☐ ☐ _____
PCR / Nucleic Acid Test* ☐not done	____/____/____		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ _____
PCR / Nucleic Acid Test* (Repeat) ☐not done	____/____/____		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ _____
Rapid Diagnostic Test (RDT) ☐not done	____/____/____		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ _____
Other: _____	____/____/____		☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ _____

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

EXPOSURE / RISK HISTORY (per Medical Provider)

Resided in U.S. prior to most recent travel? ☐Y ☐N ☐U If no, specify country: _____

HAS THE PATIENT TRAVELED OR LIVED OUTSIDE OF THE U.S. IN THE PAST 2 YEARS? ☐Y ☐N ☐U

If yes, specify below:

COUNTRY	DURATION OF STAY (specify: years, mos, wks, days)	TRAVEL DATES	NOTES
1)		Date : ____/____/____ to ____/___/____	
2)		Date : ____/____/____ to ____/___/____	
3)		Date : ____/____/____ to ____/___/____	
4)		Date : ____/____/____ to ____/___/____	

Date Returned/Arrived to U.S. ____/____/____

Onset of most recent malaria symptoms occurred in: ☐ U.S. ☐ Country outside U.S. (specify country): _____
☐ Unknown ☐ Other: _____

Principle reason for most recent travel from/to U.S.: ☐ Visiting friends/relatives ☐ New refugee/immigrant ☐ Student/teacher
☐ Missionary or dependent ☐ Airline/ship crew ☐ Peace Corps
☐ Business ☐ Military ☐ Tourism
☐ Unknown ☐ Other _____

WAS MALARIA CHEMOPROPHYLAXIS TAKEN? ☐Y ☐N ☐U Describe: ☐ Chloroquine ☐ Mefloquine ☐ Doxycycline
☐ Atovaquone/proguanil ☐ Primaquine ☐ Other: _____

Were all pills taken as prescribed? ☐Y ☐N ☐U

If doses were missed, what was the reason? ☐ Didn't think needed ☐ Was advised by others to stop ☐ Prematurely stopped taking once home
☐ Forgot ☐ Had a side effect (specify): _____
☐ Unknown ☐Other (specify): _____

Other notes from Medical Provider: