



# Malaria

Case name (last, first) \_\_\_\_\_  
 Birth date \_\_\_/\_\_\_/\_\_\_ Age at symptom onset \_\_\_\_\_  Years  Months  
 Alternate name \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Address type  Home  Mailing  Other  Temporary  Work  
 Street address \_\_\_\_\_  
 City/State/Zip/County \_\_\_\_\_  
 Residence type (incl. Homeless) \_\_\_\_\_ WA resident  Yes  No

## ADMINISTRATIVE

Investigator \_\_\_\_\_ LHJ Case ID (optional) \_\_\_\_\_  
 LHJ notification date \_\_\_/\_\_\_/\_\_\_  
**Classification**  
 Classification pending  Confirmed  Investigation in progress  Not reportable  Probable  Ruled out  Suspect  
 Investigation status  
 Complete  Complete – not reportable to DOH  Unable to complete Reason \_\_\_\_\_  In progress  
 Dates: **Investigation start** \_\_\_/\_\_\_/\_\_\_ Investigation complete \_\_\_/\_\_\_/\_\_\_ Record complete \_\_\_/\_\_\_/\_\_\_ **Case complete** \_\_\_/\_\_\_/\_\_\_

## REPORT SOURCE

**Initial report source** \_\_\_\_\_ LHJ \_\_\_\_\_  
 Reporter organization \_\_\_\_\_  
 Reporter name \_\_\_\_\_ Reporter phone \_\_\_\_\_  
 All reporting sources (list all that apply) \_\_\_\_\_

## DEMOGRAPHICS

Sex at birth:  Female  Male  Other  Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?  
**Ethnicity**  Hispanic, Latino/a, Latinx  Non-Hispanic, Latino/a, Latinx  Patient declined to respond  Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):  
**Race**  Amer Ind/AK Native (**specify:**  Amer Ind **and/or**  AK Native)  Asian  Black or African American  
 Native HI/Pacific Islander (**specify:**  Native HI **and/or**  Pacific Islander)  White  Patient declined to respond  Unk

Additional race information:  
 Afghan  Afro-Caribbean  Arab  Asian Indian  Bamar/Burman/Burmese  Bangladeshi  Bhutanese  
 Central American  Cham  Chicano/a or Chicanx  Chinese  Congolese  Cuban  Dominican  Egyptian  
 Eritrean  Ethiopian  Fijian  Filipino  First Nations  Guamanian or Chamorro  Hmong/Mong  
 Indigenous-Latino/a or Indigenous-Latinx  Indonesian  Iranian  Iraqi  Japanese  Jordanian  Karen  
 Kenyan  Khmer/Cambodian  Korean  Kuwaiti  Lao  Lebanese  Malaysian  Marshallese  Mestizo  
 Mexican/Mexican American  Middle Eastern  Mien  Moroccan  Nepalese  North African  Oromo  
 Pakistani  Puerto Rican  Romanian/Rumanian  Russian  Samoan  Saudi Arabian  Somali  
 South African  South American  Syrian  Taiwanese  Thai  Tongan  Ugandan  Ukrainian  
 Vietnamese  Yemeni  Other: \_\_\_\_\_

What is your (your child's) preferred language? Check one:  
 Amharic  Arabic  Balochi/Baluchi  Burmese  Cantonese  Chinese (unspecified)  Chamorro  Chuukese  
 Dari  English  Farsi/Persian  Fijian  Filipino/Pilipino  French  German  Hindi  Hmong  Japanese  
 Karen  Khmer/Cambodian  Kinyarwanda  Korean  Kosraean  Lao  Mandarin  Marshallese  Mixteco  
 Nepali  Oromo  Panjabi/Punjabi  Pashto  Portuguese  Romanian/Rumanian  Russian  Samoan  
 Sign languages  Somali  Spanish/Castilian  Swahili/Kiswahili  Tagalog  Tamil  Telugu  Thai  Tigrinya  
 Ukrainian  Urdu  Vietnamese  Other language: \_\_\_\_\_  Patient declined to respond  Unknown

Interpreter needed  Yes  No  Unk

**EMPLOYMENT AND SCHOOL**

Employed  Yes  No  Unk Occupation \_\_\_\_\_ Industry \_\_\_\_\_  
 Employer \_\_\_\_\_ Work site \_\_\_\_\_ City \_\_\_\_\_

Student/Day care  Yes  No  Unk  
 Type of school  Preschool/day care  K-12  College  Graduate School  Vocational  Online  Other  
 School name \_\_\_\_\_ School address \_\_\_\_\_  
 City/State/County \_\_\_\_\_ Zip \_\_\_\_\_ Phone number \_\_\_\_\_ Teacher's name \_\_\_\_\_

**COMMUNICATIONS**

Primary HCP name \_\_\_\_\_ Phone \_\_\_\_\_  
 OK to talk to patient (If Later, provide date)  Yes  Later \_\_\_/\_\_\_/\_\_\_  Never  
 Date of interview attempt \_\_\_/\_\_\_/\_\_\_  Complete  Partial  Unable to reach  Patient could not be interviewed  
 Alternate contact:  Parent/Guardian  Spouse/Partner  Friend  Other \_\_\_\_\_  
 Name \_\_\_\_\_ Phone \_\_\_\_\_

Outbreak related  Yes  No LHJ Cluster ID \_\_\_\_\_ Cluster Name \_\_\_\_\_

**CLINICAL INFORMATION**

Complainant ill  Yes  No  Unk Symptom Onset \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date \_\_\_/\_\_\_/\_\_\_  
 Illness duration \_\_\_\_\_  Days  Weeks  Months  Years Illness is still ongoing  Yes  No  Unk

**Clinical Features**

**Y N Unk**  
   **Any fever, subjective or measured** Temp measured?  Yes  No Highest measured temp \_\_\_\_\_ °F  
   Recurring fever  
   Chills or rigors  
   Sweats  
   Malaria in past 12 months (prior to this report) Date of prior illness \_\_\_/\_\_\_/\_\_\_ Prior species \_\_\_\_\_

**Complications**

**Y N Unk**  
   Acute respiratory distress syndrome (ARDS)  
   Cerebral malaria  
   Kidney (renal) abnormality or failure  
   Anemia (Hb < 11, Hct < 33)  
   Severe anemia (Hb < 7)  
   Any other complication \_\_\_\_\_

**Pregnancy**

Pregnancy status at time of symptom onset  
 Pregnant (Estimated) delivery date \_\_\_/\_\_\_/\_\_\_ Weeks pregnant at any symptom onset \_\_\_\_\_  
 OB name, phone, address \_\_\_\_\_  
 Outcome of pregnancy  Still pregnant  Fetal death (miscarriage or stillbirth)  Abortion  
 Other \_\_\_\_\_  
 Delivered – full term  Delivered – preemie  Delivered – Unk  
 Delivery method  Vaginal  C-section  Unk

Postpartum (Estimated) delivery date \_\_\_/\_\_\_/\_\_\_  
 OB name, phone, address \_\_\_\_\_  
 Outcome of pregnancy  Fetal death (miscarriage or stillbirth)  Abortion  
 Other \_\_\_\_\_  
 Delivered – full term  Delivered – preemie  Delivered – Unk  
 Delivery method  Vaginal  C-section  Unk

Neither pregnant nor postpartum  Unk

**Clinical testing**

% Parasitemia \_\_\_\_\_

**Hospitalization**

**Y N Unk**  
   Hospitalized at least overnight for this illness Facility name \_\_\_\_\_  
 Hospital admission date \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_ HRN \_\_\_\_\_  
   Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

**Y N Unk**  
   Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ *Please fill in the death date information on the Person Screen*  
   Autopsy performed  
   Death certificate lists disease as a cause of death or a significant contributing condition  
 Location of death  Outside of hospital (e.g., home or in transit to the hospital)  Emergency department (ED)  
 Inpatient ward  ICU  Other \_\_\_\_\_

**RISK AND RESPONSE (Ask about exposures 7-30 days before symptom onset)**

**Travel**

	Setting 1	Setting 2	Setting 3
<b>Travel out of</b>	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
<b>Destination name</b>			
<b>Start and end dates</b>	____/____/____ to ____/____/____	____/____/____ to ____/____/____	____/____/____ to ____/____/____

**Risk and Exposure Information**

**Y N Unk**

- Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country \_\_\_\_\_  
   Does the case know anyone sharing travel with similar symptoms of illness  
   In last 12 months before symptom onset, blood transfusion or organ transplant Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Reason \_\_\_\_\_

**Exposure and Transmission Summary**

**Likely geographic region of exposure**  In Washington – county \_\_\_\_\_  Other state \_\_\_\_\_  
 Not in US - country \_\_\_\_\_  Unk

International travel related  During entire exposure period  During part of exposure period  No international travel

**Public Health Issues**

**Y N Unk**

- Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis Agency and location \_\_\_\_\_  
 Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Specify type of donation \_\_\_\_\_

**Public Health Interventions/Actions**

**Y N Unk**

- Notified blood or tissue bank (if recent donation)

**TREATMENT**

**Y N Unk**

- Did patient receive prophylaxis/treatment  
 Specify Anti-malarial \_\_\_\_\_  
 Number of days actually taken \_\_\_\_\_ Treatment start date \_\_\_\_/\_\_\_\_/\_\_\_\_ Treatment end date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 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 of the doses  No-missed half or more of the doses  
 No-missed doses but not sure how many  Unk  
 Reason for missed doses  Forgot  Didn't think needed  Had side effects (specify \_\_\_\_\_)  
 Advised by others to stop  Prematurely stopped taking once home  Unk  
 Other \_\_\_\_\_

**NOTES**

**LAB RESULTS**Lab report information**Lab report reviewed – LHJ** 

WDRS user-entered lab report note \_\_\_\_\_

Submitter \_\_\_\_\_

Performing lab for entire report \_\_\_\_\_

Referring lab \_\_\_\_\_

Specimen**Specimen identifier/accession number** \_\_\_\_\_**Specimen collection date** \_\_\_/\_\_\_/\_\_\_ **Specimen received date** \_\_\_/\_\_\_/\_\_\_**WDRS specimen type** \_\_\_\_\_

WDRS specimen source site \_\_\_\_\_

WDRS specimen reject reason \_\_\_\_\_

Test performed and result**WDRS test performed** \_\_\_\_\_**WDRS test result, coded** \_\_\_\_\_

WDRS test result, comparator \_\_\_\_\_

**WDRS result, numeric only** (enter only if given, including as necessary **Comparator** and **Unit of measure**) \_\_\_\_\_

WDRS unit of measure \_\_\_\_\_

Test method \_\_\_\_\_

WDRS interpretation code \_\_\_\_\_

Test result – Other, specify \_\_\_\_\_

**WDRS result summary**  Positive  Negative  Indeterminate  Equivocal  Test not performed  PendingTest result status  Final results; Can only be changed with a corrected result Preliminary results Record coming over is a correction and thus replaces a final result Results cannot be obtained for this observation Specimen in lab; results pending

Result date \_\_\_/\_\_\_/\_\_\_

**Upload document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_

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