Reporting Centre: _____ Date of reporting: YYYY /MM / DD
Patient's name: _____ Age: _____yrs Sex: M F

Present Address	Permanent Home address
Workplace Address	School Address

Clinical Data
Date of onset of THIS attack: YYYY /MM / DD Place of onset of THIS attack: _____

Name/Address/Phone No. of Reporting Physician:_____
_____

Symptom/ Signs	Y/N	Symptom /Signs	Y/N	Symptom/Signs	Y/N	Symptom/Signs
Fever		Chills		Myalgia		Headache
Sweating		Nausea		Vomiting		Other (Specify)
Complications						

LABORATORY RESULTS
Optima: Date taken YYYY /MM / DD Positive Negative Not taken
Smear: Date taken YYYY /MM / DD Positive Negative Not taken
SPECIES: Vivax Ovale Falciparum Not determined

Has patient been out of country? Yes No	Has patient's contact been out of country? Yes No
If yes, list all countries visited with dates	If yes, list all countries visited with dates

Malaria prophylaxis taken? Yes No Drugs: Chloroquine Primaquine Fansidar Other ____

Local Travel History / Overnight stay in past 3 months	(Contact info)
Blood transfusion within past 2 years? Yes No If yes, date/s	Has the patient had a past history of confirmed malaria? No/Yes _____

Treatment (Dose and Duration)
Chloroquine _____Primaquine _____ Quinine_____
Pyrimethamine/sulphadoxine_____ Amodiaquine _____ Mefloquine_____

Final case classification: Malaria Y / N Laboratory confirmed Y/ N	**CLASSIFICATION**: Imported Induced Cryptic Introduced Indigenous Congenital

Additional Information:_____
_____
_____
_____
_____

Signature:_____ Investigator:_____Date reported: YYYY /MM / DD