MALARIA CASE SURVEILLANCE REPORT IN RWANDA

Case N°…… Date: ____/ ____/ _____ (mm/dd/yyyy):

District: …… District Hospital: …… Health Center: …… Sector……..

Cell……Village……Number of Household Members ☐☐

Patient name (last, first):
ID Number……..
Occupation
☐ None
☐ Farmer
☐ Servant (Public and Private)
☐ Business
☐ Students
☐ Other(Specify)_____
Date of symptom onset of fever (mm/dd/yyyy): ____/ ____/ _____

Age (yrs): _____ (mos): _____
Date of birth: ____/ ____/ _____
Sex :
☐ Male
☐ Female
Is patient pregnant? ☐ Yes ☐ No
LLINs Ownership ? ☐ Yes ☐ No
LLINs usually used? ☐ Yes ☐ No

Lab results:
☐ Blood smear/RDT positive ☐ Blood smear/RDT Negative
☐ No Blood smear/RDT Taken
Species (check all that apply):
☐ Vivax ☐ Falciparum ☐ Malariae ☐ Ovale ☐ Not Determined

Patient admitted to hospital: ☐ Yes ☐ No
Hospital: _____
Date: ____/ ____/ _____ Hospital record No.: _____

If patient have been admitted, describe the clinical complication: ☐ Cerebral malaria ☐ Renal failure ☐ Anemia ☐ None ☐ Other : _____
Was illness fatal: Yes ☐ No ☐ Unknown ☐ .If yes, date of death : _____/____/_____

Therapy received (check all that apply): ☐ Artesunate ☐ ACTs ☐ Quinine ☐ PRIMO ☐ Unknown ☐ Other (specify): _____

Has the patient traveled or lived outside the Health Center catchment area during the past two weeks? Yes ☐ No ☐ If yes, specify:

Country:	1. _____	2. _____	3. _____
District:	1. _____	2. _____	3. _____
Sector :	1. _____	2. _____	3. _____
Cell:	1. _____	2. _____	3. _____
Village:	1. _____	2. _____	3. _____
Date returned/arrived (mm/dd/yyyy):	____/ ____/ _____	____/ ____/ _____	____/ ____/ _____

Did patient reside in his/her village prior to most recent travel?
☐ Yes, for ≥12 months
☐ Yes, for <12 months
☐ No, (specify District):
_____
☐ Unknown

Principal reason for travel for most recent trip:
☐ Tourism
☐ Military
☐ Business
☐ Students/Teachers
☐ Visiting friends/relatives
☐ Airline/ship crew
☐ Manpower
☐ Refugee/immigrant
☐ Other:
_____

For MOPDD Use Only: Classification: ☐ Imported ☐ Induced ☐ Introduced ☐ Relapsing ☐ Indigenous

Physician (Name, Surname): Telephone No: ( ) _____ Signature