

Your Reference No.

MRL No. ___ / ___ / ___

**HEALTH PROTECTION AGENCY
MALARIA REFERENCE LABORATORY
PATIENT REPORT FORM**

In Confidence

Date -----/-----/-----

Family name: _____

All other names: _____

Home post code:

Primary Care Trust:

Address in U.K: _____

Date of birth: ____/____/____

Age _____

Sex : M / F

Country of birth: _____

Country of usual residence: _____

Ethnicity:(mark one)	Reason for travel:(mark one)	Malaria prophylaxis taken:(mark as relevant)
<input type="checkbox"/> White British <input type="checkbox"/> Other White background <input type="checkbox"/> Black African <input type="checkbox"/> Black Caribbean <input type="checkbox"/> Other Black background <input type="checkbox"/> Indian Sub-Continent <input type="checkbox"/> South-East Asian <input type="checkbox"/> Other Asian background <input type="checkbox"/> Mixed ethnicity <input type="checkbox"/> Other (please specify)	<input type="checkbox"/> New Entrant to UK <input type="checkbox"/> Visiting family in country of origin <input type="checkbox"/> UK citizen living abroad <input type="checkbox"/> Civilian sea/air crew <input type="checkbox"/> British armed forces <input type="checkbox"/> Business/Professional travel <input type="checkbox"/> Foreign student studying in UK <input type="checkbox"/> Holiday travel to malarious country <input type="checkbox"/> Foreign visitor ill while in UK <input type="checkbox"/> Children visiting parents living abroad <input type="checkbox"/> Other (please specify)_____	<input type="checkbox"/> NONE <input type="checkbox"/> Mefloquine (Lariam) <input type="checkbox"/> Malarone <input type="checkbox"/> Doxycycline <input type="checkbox"/> Chloroquine (Nivaquine/Avloclor) <input type="checkbox"/> Proguanil (Paludrine) <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ Prophylaxis taken regularly? Y / N Continued on return for _____ weeks

Date of onset of illness: ____/____/____

Date of starting treatment: ____/____/____

Date of arrival in U.K. from malarious country: ____/____/____

For India, please specify areas visited

Duration of stay abroad : _____

Country (ies) where infection acquired : _____

G.P. Name & Address:

Tel.No.

Name & Contact Details of person completing this form if not the G.P.

Laboratory/Hospital where diagnosis made: _____

Date of diagnosis: ____/____/____

Date of sample: ____/____/____

Method of diagnosis: Blood film Antigen test Clinical
please specify _____

Species of malarial parasite:

- P.falciparum P.ovale
 P.vivax Species unknown
 P.malariae No malaria parasites found

Was patient treated as an outpatient inpatient Was this patient admitted to ITU/HDU? Y / N
Duration of stay in hospital _____ days.
Pregnant? Y / N -----/40

Outcome of illness: Recovery Death Unknown

Any other information relevant to this case: _____

MALARIA IS A NOTIFIABLE DISEASE- PLEASE FILL IN A STATUTORY NOTIFICATION FORM AND FORWARD TO THE CCDC.

Please return this form to:

**HPA Malaria Reference Laboratory
London School of Hygiene & Tropical Medicine
Keppel Street (Gower Street)
London WC1E 7HT**

Tel. no: surveillance **020 7927 2435**
laboratory **020 7927 2427**
fax **020 7637 0248**

MALARIA LAB. USE ONLY

If sending slides, please indicate where and to whom results should be sent.