PARENTERAL THERAPY FOR SEVERE MALARIA - FORM A
To be completed by the Attending Physician

1. Date of request (D/M/Y):_____

2. Drug requested: [ ]Artesunate [ ]Quinine

3. Requesting/Attending physician:_____

4. Requesting site:_____
Province of diagnosis:_____

5. Patient initials (first/middle/last):_____
Date of birth:_____ Sex: [ ] Male [ ] Female

6. Canadian born: [ ] Yes [ ] No
If no, country of birth:_____
Canadian resident: [ ] Yes [ ] No
Visitor: [ ] Yes [ ] No

7. If <18 years of age, country of parental origin:
_____

8. Presumed country(ies) of acquisition:_____

9. Reasons for travel (check all that apply):
[ ] Business [ ] Medical tourism
[ ] Immigration [ ] Visiting friends/relatives
[ ] Vacation [ ] Volunteer/missionary
[ ] Education [ ] Military
[ ] Other (specify):_____

10. Travel dates (note for new immigrants and visitors, will only have date arrived in Canada)
Date departed Canada (D/M/Y):_____
Date returned to or arrived in Canada (D/M/Y):_____

11. Date became ill (D/M/Y):_____

12. Date of 1st physician visit (D/M/Y):_____

13. Was the patient admitted to hospital?: [ ] Yes [ ] No

14. Malaria prevention:
a. Pre-travel advice sought: [ ] Yes [ ] No
If yes, with whom?
[ ] GP/family physician [ ] Travel medicine clinic
[ ] Other (specify):_____
b. Insect precautions? [ ]Yes [ ]No [ ]Inconsistent
c. Chemoprophylaxis:
Suggested? [ ] Yes [ ] No [ ] Unknown
Prescribed? [ ] Yes [ ] No [ ] Unknown
Used? [ ] Yes [ ] No [ ] Unknown
Adherence: Did they take the drug as prescribed (before, during, after travel, missed ≤2 doses)?
[ ] Yes [ ] No [ ] Unknown
Chemoprophylaxis type:
[ ] chloroquine [ ] doxycycline [ ] malarone
[ ] mefloquine [ ] other (specify):_____

15. Diagnosis:
Lab-confirmed: [ ] Yes [ ] No
Date (D/M/Y):_____Time:_____
Test used (check all that apply):
[ ] RDT [ ] Thick and thin smear
[ ] Other (specify):_____
Malaria species (check all that apply):
[ ] *P. falciparum* [ ] *P. vivax*
[ ] *P. malariae* [ ] *P. ovale*
[ ] *P. knowlesii* [ ] Unknown
Percent parasitemia (%):
At initial diagnosis:_____
At time of starting IV therapy:_____

16. Has the patient had other medical treatment for this episode of malaria?
[ ] Yes [ ] No [ ] Unknown
If yes, specify what drug(s):_____
Who prescribed the drug?
[ ] Self prescribed
[ ] MD in Canada
[ ] MD in country of acquisition
[ ] Other (specify):_____

17. Indication for use of IV antimalarial therapy (Check all that apply):
[ ] Continued vomiting or unable to tolerate oral therapy (Note: if this is the only indication for IV therapy, then QUININE preferred)
[ ] Impaired consciousness or coma
[ ] Abnormal bleeding/DIC
[ ] Severe anemia (Hb ≤50g/L)
[ ] Hemoglobinuria (macroscopic)
[ ] Renal failure (Cr >265µmol/L or >upper limit for age for children
[ ] Pulmonary edema/ARDS/respiratory failure
[ ] Hypoglycemia (<2.2mmol/L)
[ ] Parasitemia (≥2% in non-immune, ≥5% in semi-immune)
[ ] Acidemia/acidosis (pH<7.25, HCO_3<15mmol/L or venous lacate>5mmol/L)
[ ] Repeated generalized convulsions (≥3 in 24hrs)
[ ] Circulatory collapse/shock (SBP<80mmHg + cold extremities
[ ] Jaundice (Total bilirubin >45µmol/L)
[ ] Other (specify):_____

The following refer to time taken to begin IV therapy and is used to establish where/why delays occur.

18. Number of hours to contact individual responsible for dispensing IV malaria therapy through the Canadian Malaria Network (# hours):_____

19. Number of hours from request until drug received by pharmacy (# hours):_____

20. Number of hours from time received in pharmacy until drug administered (# hours):_____

21. Comments/perceived reasons for the delay(s):

_____

_____

*Completed by:*_____ *Date:*_____

Thank you very much for completing this form.
Please complete Form B (follow-up) at day 7 and send it in.
Your cooperation is greatly appreciated.

PLEASE COMPLETE AND RETURN TO THE CMN COORDINATING CENTRE BY E-MAIL: jlevine@ohri.ca OR BY FAX: 613-737-8164 WITHIN 48 HOURS OF IV DRUG REQUEST.

Parenteral artesunate and quinine are provided by Health Canada's Special Access Program through the Canada Malaria Network (CMN).