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

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

2. Date IV drug requested (D/M/Y):_____

3. Drug requested: [ ] Artesunate [ ] Quinine

4. Requesting/Attending physician:
_____

5. Requesting site:_____
Province of requesting site:_____

6. Patient initials (first/middle/last):_____
Date of birth (D/M/Y):_____ Sex: [ ] Male [ ] Female

7. Date diagnosed (D/M/Y):_____

8. Date given 1st dose of IV drug (D/M/Y):_____

9. Patient outcome as of today's date (check all that apply):
[ ] Alive [ ] Still hospitalized
[ ] Discharged Date (D/M/Y):_____
[ ] Deceased Date (D/M/Y):_____

10. Hospitalization
Total days hospitalized:_____
Days in ICU:_____

11. Drug utilization
Number of doses of IV drug administered:_____
Number of vials used:_____

12. Step-down therapy or second antimalarial (please specify and give number of DAYS of therapy):
[ ] Clindamycin (# days):_____
[ ] Doxycycline (# days):_____
[ ] Malarone (# days):_____
[ ] Quinine oral (# days):_____
[ ] Other (specify):_____ (# days):_____

13. Number of days until negative smear achieved:_____

14. Malaria complications (check all that apply):
[ ] Impaired consciousness or coma
[ ] Spontaneous bleeding/DIC

15. Malaria complications (check all that apply):
[ ] Impaired consciousness or coma
[ ] Spontaneous bleeding/DIC
[ ] Severe anemia (Hb ≤50 g/L)
[ ] Renal failure (Cr>265 μmol/L or >upper limit for age for children
[ ] Pulmonary edema/ARDS/resp failure
[ ] Circulatory collapse/shock (SBP<80mmHg + cold extremities)
[ ] Seizures
[ ] Multiorgan failure
[ ] Other:_____

16. Were there any complications or adverse events related to IV antimalarial drug?
[ ] Yes [ ] No
If yes, please specify:_____

17. Is this program to provide IV malaria therapy helpful to you? [ ] Yes [ ] No

18. Did you consult with a physician through the Canadian Malaria Network?
[ ] Yes [ ] No

19. If yes, was this a beneficial interaction?
[ ] Yes [ ] No

20. Comments:_____
_____
_____

21. Suggestions to improve the program:_____
_____
_____
_____

Thank you for completing this form.
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).