Malaria Test

Patient information	
Name:	
Date of birth:	
Gender:	
Patient ID:	
Date of test:	
Screening questions	

1. Have you experienced any of the following symptoms (Select all that apply)

Fevers	Fatigue
Chills	Muscle pain
Headache	Nausea or vomiting
Other (please specify):	

2. Have you traveled to a malaria-endemic area in the past 12 months?

Yes	No

3. Do you know if you have been bitten by mosquitoes in a malaria-endemic area?

Yes	No

4. Have you received any malaria prophylaxis medications?

Yes	No

5. Are you currently experiencing any other health issues?

Yes (please specify):
No

Sample type:
Sample collected by:
Type of test conducted (select all that apply)

Rapid diagnostic test (RDT)	Microscopic examination (Blood smear)
PCR testing	
Other (please specify):	

Results	
	Positive (Malaria infection confirmed): Presence of malaria antigens indicates an active malaria infection. Prompt treatment is required.
	Negative (No malaria detected): Absence of malaria parasites suggests no malaria infection.

Additional notes

Name of healthcare provider:

Medical license number:

Contact information:

Signature: