Patient Name: ______________________________ Patient Age: |____|____| . |____|

Patient Sex: Male ☐ Female ☐

FORM HIFM3 - MALARIA RAPID TEST RESULTS

Date of Test: |___||___| / |___||___| / |___||___||___||___| or Not Done ☐1 ________________
Day Month Year

a) Malaria Antigen Test Result (check all that apply):

P. falciparum ☐ 1

P. malarie ☐ 1

P. ovale ☐ 1

P. vivax ☐ 1

Other species ☐ 1

All negative ☐ 1

b) Photos Taken of Strip?

Yes ☐ 1

No ☐ 2

Hospital ID

(stick label here)

Initials/Date

Transcribed by: ________________________

Checked by: ________________________

Subject ID

(stick label here)

Top Copy: Affix Hospital ID label and Return to Study Office

Bottom Copy: Retain by Lab