Legionellosis

Agency: ____ Investigator: ____ Phone number: ____

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: ____
First and middle name: ____
Maiden name: ____ Suffix: ____
Address line: ____
Zip: ____ City: ____
State: ____ County: ____
Phone: ( )- - Type: ____
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name: ____

Date of Birth: / / Estimated? ☐ Age: ____
Gender: ☐ Female ☐ Male ☐ Other ____
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name: ____
Parent/Guardian phone: ( )- - Type: ____

EVENT

Disease type: ☐ Legionnaires Disease ☐ Pontiac Fever ☐ Extrapulmonary Legionellosis **(FOR STATE USE ONLY)**

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of Death / /
Event exception ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ____
Exposure setting: ____
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ____ Country: ____

Healthcare provider information

Last name: ____
First name: ____
Provider title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
Facility name: ____
Address line 1: ____
Address line 2: ____
Zip code: ____ City: ____
State: ____ County: ____
Phone : ( )- - Type: ____

LABORATORY FINDINGS

Laboratory: ____ Accession #: ____ Collection date: / /
Date received: / / Specimen source: ____ Test type: ____
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other ____
Organism: Serogroup

Laboratory: ____ Accession #: ____ Collection date: / /
Date received: / / Specimen source: ____ Test type: ____
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other ____
Organism: Serogroup

Laboratory: ____________ Accession #: ____________ Collection date: ___/___/___

Date received: ___/___/___ Specimen source: ____________ Test type: ____________

Result type: ☐ Preliminary ☐ Final Result date: ___/___/___ Result: ☐ Positive ☐ Negative ☐ Other ________

Organism: Serogroup

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: ____________
Job title: ____________
Facility name: ____________
Address: ____________
City ____________ State: ____________
Zip code: ____________ County: ____________
Phone: (   )-   -   Type:

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Job title: ____________
Facility name: ____________
Address: ____________
City ____________ State: ____________
Zip code: ____________ County: ____________
Phone: (   )-   -   Type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ____________

Admission date: ___/___/___ Discharge date: ___/___/___ Days hospitalized: ____________

CLINICAL INFO & DIAGNOSIS

Symptoms

Fever: ☐ Yes ☐ No ☐ Unknown Onset date: ___/___/___ Highest known fever: _____ ☐ Celsius ☐ Fahrenheit

Cough ☐
Muscle pain ☐
Pneumonia ☐

NOTE: Pneumonia can be clinical or radiographic and is needed for case definition

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic: ____________
Date started: ___/___/___
Dose: ____________
Unit: ☐ mg ☐ ml ☐ IU
# of days: ______ # of times a day: ______
Route: ____________

Antibiotic: ____________
Date started: ___/___/___
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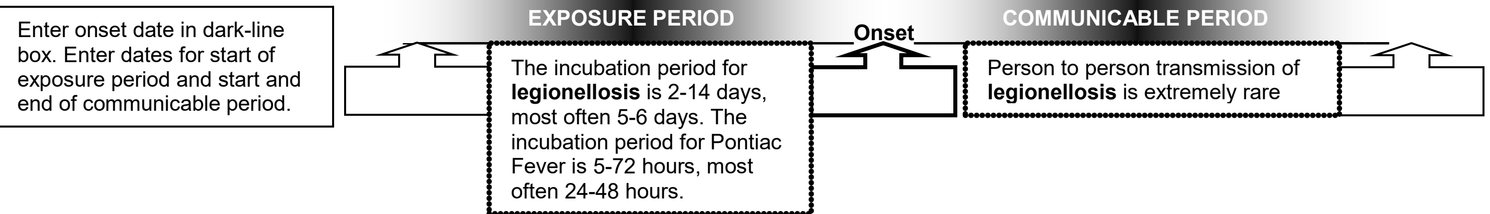
Date started: ___/___/___
Dose: ____________
Unit: ☐ mg ☐ ml ☐ IU
# of days: ______ # of times a day: ______
Route: ____________

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Travel Information – *In the 14 days before onset of symptoms did the case:*

Spend any nights away from home (excluding healthcare settings)? ☐ Yes ☐ No ☐ Unknown

If yes, complete the table below:

Accommodation name	Address	Zip	City	State	Country	Room Number	Arrival date	Departure date

Visit or stay in an inpatient or outpatient healthcare, long-term care, assisted living or senior living facility?

☐ Yes ☐ No ☐ Unknown

If yes, complete the table below:

Healthcare setting	Type of exposure	Is facility a transplant center?	Reason for visit / stay	Facility/setting name	Address, City, State, Zip	Visit/ admission date	End date
☐ Hospital ☐ Long term care ☐ Clinic ☐ Assisted living ☐ Senior living ☐ Other:	☐ Inpatient ☐ Outpatient ☐ Resident ☐ Visitor ☐ Employee	☐ Yes ☐ No ☐ Unknown					
☐ Hospital ☐ Long term care ☐ Clinic ☐ Assisted living ☐ Senior living ☐ Other:	☐ Inpatient ☐ Outpatient ☐ Resident ☐ Visitor ☐ Employee	☐ Yes ☐ No ☐ Unknown					
☐ Hospital ☐ Long term care ☐ Clinic ☐ Assisted living ☐ Senior living ☐ Other:	☐ Inpatient ☐ Outpatient ☐ Resident ☐ Visitor ☐ Employee	☐ Yes ☐ No ☐ Unknown					

Water Exposures – *In the 14 days prior to onset of symptoms did the case:*

Have exposure to any of the following, either while traveling or at home? ☐ Yes ☐ No ☐ Unknown

If yes to either, complete the table below:

Exposures	Yes	No	Unknown	Location	Date(s)
Hot tub, Jacuzzi®, or whirlpool spa					
Sat NEAR a working hot tub but did not get in					
Pool					
Recreational misters					
Outdoor cooling mister					
Lawn or golf course sprinkler					
Steam room or wet sauna					

Exposures	Yes	No	Unknown	Location	Date(s)
Decorative fountain or waterfall					
Humidifier					
Shower (away from home only)					

Other Exposures – *In the 14 days prior to onset of symptoms did the case:*

Use respiratory therapy equipment (e.g. nebulizer, CPAP, BiPAP) for the treatment of sleep apnea, COPD, asthma, for oxygen therapy, or for any other reason? ☐ Yes ☐ No ☐ Unknown

If yes, does this device use a humidifier? ☐ Yes ☐ No ☐ Unknown

If used a humidified device, what type of water was used (check all that apply) ☐ Sterile ☐ Distilled ☐ Bottled ☐ Tap ☐ Unknown ☐ Other (specify, below)

Other type of water: ________________________________

If used a device, how do you clean it? ________________________________

Received dialysis:	☐ Yes ☐ No ☐ Unknown	From date: / /	To date: / /
Worked with a case:	☐ Yes ☐ No ☐ Unknown	From date: / /	To date: / /
Lived with another case:	☐ Yes ☐ No ☐ Unknown	From date: / /	To date: / /

Does the patient have a history of any of the following other exposures or risk factors:

Received organ transplant:	☐ Yes ☐ No ☐ Unknown	Date received: / /	Organ type:
Cancer:	☐ Yes ☐ No ☐ Unknown	From date: / /	To date: / /
Received radiation therapy:	☐ Yes ☐ No ☐ Unknown	From date: / /	To date: / /
Received chemotherapy:	☐ Yes ☐ No ☐ Unknown	From date: / /	To date: / /
Smoked cigarettes:	☐ Yes ☐ No ☐ Unknown	Packs per day:	☐ >2 packs a day ☐1 to 2 packs a day ☐ Less than a pack a day

NOTES: ________________________________