Patient's Name: _____ Telephone Number: _____ Hospital: 58237-9 _____

LAST / FIRST / MI

Address: _____ _____ Patient Chart No: _____

NUMBER / STREET / APT NO / CITY PID-11.3 STATE ZIP CODE PID-11.5

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC

CDC National Center for Immunization and Respiratory Diseases

LEGIONELLOSIS CASE REPORT

GENERIC MMG **(DISEASE CAUSED BY ANY LEGIONELLA SPECIES)** LEGIONELLA MMG (RIBD_V1.0_MMG_F_20191003)

Department of Health & Human Services
Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, 30329

Case No. : ☐☐☐☐☐☐
(CDC use only)

PATIENT INFORMATION

1. State Health Dept. Case No.: 77993-4

2. Reporting State: 77966-0 ☐☐

3. County of Residence: PID-11.9

4. State of Residence: PID-11.4 ☐☐

5. Occupation: 85658-3

6a. Date of Birth: PID-7 ☐☐ ☐☐ ☐☐☐☐ (Mo. Day Year)

6b. Age: ☐☐☐ 77998-3 1 ☐ Days 2 ☐ Mos 3 ☐ Years OBX-6

7. Sex: PID-8 1 ☐ Male 2 ☐ Female

8. Ethnicity: PID-22 1 ☐ Hispanic/Latino 2 ☐ Not Hispanic/Latino 9 ☐ Unknown

9. Race: (check all that apply) PID-10 1 ☐ American Indian/ Alaska Native 1 ☐ Asian 1 ☐ Black or African American 1 ☐ White 1 ☐ Native Hawaiian or Other Pacific Islander 1 ☐ Unknown

CLINICAL ILLNESS

10. Diagnosis: (check one) INV1059
1 ☐ Legionnaires' Disease (pneumonia, clinical or X-ray diagnosed)
2 ☐ Pontiac Fever (fever and myalgia without pneumonia)
8 ☐ Extrapulmonary Legionellosis: _____

11. Date of symptom onset of legionellosis: 11368-8 ☐☐ ☐☐ ☐☐☐☐ (Mo. Day Year)

12. Date of first report to public health at any level: 77970-2 ☐☐ ☐☐ ☐☐☐☐ (Mo. Day Year)

13. Was the patient hospitalized during treatment for legionellosis? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 77974-4
Hospital name: _____
If yes, date of admission: ☐☐ ☐☐ ☐☐☐☐ 8656-1 (Mo. Day Year) City INV1060 State INV1061 _____

14. Outcome of illness:
1 ☐ Survived 3 ☐ Still ill
2 ☐ Died 9 ☐ Unknown

EXPOSURE INFORMATION

15. **In the 14 days before onset,** did the patient spend any nights away from home (excluding healthcare settings)? INV1062
(check one) 1 ☐ Yes* 2 ☐ No 9 ☐ Unknown *If yes, please complete the following table.*

ACCOMMODATION NAME TRAVEL42	ADDRESS TRAVEL43	CITY TRAVEL45	STATE TRAVEL44	ZIP TRAVEL51	COUNTRY TRAVEL46	ROOM NUMBER	DATES OF STAY	
							ARRIVAL	DEPARTURE
						TRAVEL47	TRAVEL49	TRAVEL50

*If yes, was this case reported to CDC at travellegionella@cdc.gov? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

16. **In the 14 days before onset,** INV1085 did the patient get in or spend time near a whirlpool spa PHC367 (i.e., hot tub) ?
(check one) INV1086 1 ☐ Yes 2 ☐ No 9 ☐ Unknown *If yes, describe where:* INV1087 _____ *If yes, list dates:* INV1088 _____

17. **In the 14 days before onset,** did the patient use a nebulizer, CPAP, BiPAP or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma or for any other reason? INV1089
(check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown *If yes, does this device use a humidifier?* 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If yes, what type of water is used in the device? (chec INV1090 *pply)* 1 ☐ Sterile 1 ☐ Distilled 1 ☐ Bottled 1 ☐ Tap 1 ☐ Other 1 ☐ Unknown

18. **In the 14 days before onset,** INV1063 atient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?
(check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown *If yes, please complete the following table.*

TYPE OF HEALTHCARE SETTING / FACILITY (CHECK ONE) 81267-7	TYPE OF EXPOSURE (CHECK ONE) INV1064	NAME OF FACILITY 76696-4	IS THIS FACILITY ALSO A TRANSPLANT CENTER?	REASON FOR VISIT INV1066	CITY 65647-0	STATE 68488-6	DATE OF VISIT / ADMISSION	
							START DATE	END DATE
1 ☐ Hospital 2 ☐ Long term care 3 ☐ Clinic 8 ☐ Other: _____	1 ☐ Inpatient 2 ☐ Outpatient 3 ☐ Visitor or volunteer 4 ☐ Employee		1 ☐ Yes 2 ☐ No 9 ☐ Unknown INV1065				INV1067	INV1068
1 ☐ Hospital 2 ☐ Long term care 3 ☐ Clinic 8 ☐ Other: _____	1 ☐ Inpatient 2 ☐ Outpatient 3 ☐ Visitor or volunteer 4 ☐ Employee		1 ☐ Yes 2 ☐ No 9 ☐ Unknown INV1065					

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address. While your response is voluntary your cooperation is necessary for the understanding and control of this disease.

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

State Health Dept. Case No.:_____ 77993-4

19. Was this case associated with a healthcare exposure: (check one) INV1071

1 ☐ **Presumptive:** Patient had 10 or more days of continuous stay at a healthcare facility during the 14 days before onset of symptoms.
2 ☐ **No:** No exposure to a healthcare facility in the 14 days prior to onset
3 ☐ **Possibly:** Patient had exposure to a healthcare facility for a portion of the 14 days prior to onset
8 ☐ **Other (specify)** _____ 9 ☐ **Unknown**

20. **In the 14 days before onset,** did patient visit or stay in an assisted living facility or senior living facility? (check one) INV1072 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

TYPE OF FACILITY INV1074	TYPE OF EXPOSURE INV1075	NAME OF FACILITY INV1076	CITY INV1078	DATE OF VISIT	
				START DATE	END DATE
1 ☐ Assisted Living	1 ☐ Resident 2 ☐ Visitor or Volunteer 3 ☐ Employee			INV1081	INV1082
2 ☐ Senior Living (Includes retirement homes without skilled nursing or personal care	1 ☐ Resident 2 ☐ Visitor or Volunteer 3 ☐ Employee				

21. Was this case associated with a known outbreak or possible cluster? (check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 77980-1

If yes, specify name of facility, city, and state of outbreak: 77981-9 _____

LABORATORY DATA

PLEASE CHECK ALL METHODS OF DIAGNOSIS WHICH APPLY:

1 ☐ CONFIRMED CASE 77990-0

1 ☐ **Urinary Antigen Positive:** *If yes,* LAB693

Date Collected: ☐☐ ☐☐ ☐☐☐☐ 68963-8
Mo. Day Year

2 ☐ **Culture Positive:** *If yes,* LAB695

Date Collected: ☐☐ ☐☐ ☐☐☐☐ 68963-8
Mo . Day Year

Site: 66746-9 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid
4 ☐ blood 8 ☐ other (specify) _____

Species: LAB278 _____ Serogroup: INV705 _____

3 ☐ **Fourfold rise in antibody titer to** LAB714 ***Legionella pneumophila* serogroup 1:** *If yes,*

Initial (acute) titer: _____ Date Collected: ☐☐ ☐☐ ☐☐☐☐ 68963-8
LAB669 Mo. Day Year

Convalescent titer: _____ Date Collected: ☐☐ ☐☐ ☐☐☐☐ 68963-8
LAB670 Mo. Day Year

3 ☐ PROBABLE CASE

Indicate epidemiologic link in notes field

2 ☐ SUSPECT CASE 77990-0

4 ☐ **Fourfold rise in antibody titer OTHER THAN *Legionella*** LAB715 ***pneumophila* serogroup 1 or to multiple species or serogroups of *Legionella* using pooled antigen:** *If yes,*

Initial (acute) titer: _____ Date Collected: ☐☐ ☐☐ ☐☐☐☐
LAB669 Mo. Day Year

Convalescent titer: _____ Date Collected: ☐☐ ☐☐ ☐☐☐☐
LAB670 Mo. Day Year

Species: LAB278 _____ Serogroup: INV705 _____

5 ☐ **Direct Fluorescent Antibody (DFA) or** LAB694 **Immunohistochemistry (IHC) Positive:** *If yes,*

Date Collected: ☐☐ ☐☐ ☐☐☐☐
Mo. Day Year

Site: 66746-9 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid
4 ☐ blood 8 ☐ other (specify) _____

Species: LAB278 _____ Serogroup: NV705 _____

6 ☐ **Nucleic Acid Assay (e.g., PCR):** *If yes,* LAB696

Date Collected: ☐☐ ☐☐ ☐☐☐☐
Mo. Day Year

Site: 66746-9 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid
4 ☐ blood 8 ☐ other (specify) _____

Species: LAB278 _____ Serogroup: INV705 _____

INTERVIEWER IDENTIFICATION

Interviewer's Name:	State Health Dept. Official who reviewed this report:
Affiliation:	Title:
Telephone No.:	Telephone No.:

REPORTING INSTRUCTIONS

Local Health Dept. Please submit this document to:
State/DHD/SSS via your CD clerk

State Health Dept. Return completed form to:
Respiratory Diseases Branch, Mailstop H24-6
Office of Infectious Diseases
Centers for Disease Control and Prevention
1600 Clifton Rd. NE, Atlanta, GA 30329

COMMENTS