Reset Patient ID Info

Patient's Name: _____ Telephone Number: _____ Hospital: _____
LAST / FIRST / MI

Address: _____ _____ Patient Chart No.: _____
NUMBER / STREET / APT NO / CITY / STATE ZIP CODE

PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC

Form Approved OMB No. 0920-0728

CDC • National Center for Immunization and Respiratory Diseases

LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY *LEGIONELLA* SPECIES)

Reset Form

Department of Health & Human Services
Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, 30329-4027
http://www.cdc.gov/legionella/index.htm

Case No.: ☐☐☐☐☐☐ (CDC use only)

1. State Health Dept. Case No.:	2. Reporting State: ☐☐	3. County of Residence:	4. State of Residence: ☐☐	5. Occupation:

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

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

7. Sex: 1 ☐ Male 2 ☐ Female

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

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

10. Diagnosis: (check one)
1 ☐ Legionnaires' Disease (pneumonia, clinical or X-ray diagnosed)
2 ☐ Pontiac Fever (fever and myalgia without pneumonia)
8 ☐ Other (e.g., endocarditis, wound infection): _____

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

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

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

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

15. In the 10 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?
(check one) 1 ☒ Yes* 2 ☐ No 9 ☐ Unknown *If yes, please complete the following table.*

ACCOMMODATION NAME	ADDRESS	CITY	STATE	ZIP	COUNTRY	ROOM NUMBER	DATES OF STAY	
							ARRIVAL	DEPARTURE

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

16. In the 10 days before onset, did the patient get in or spend time near a whirlpool spa (i.e., hot tub)?
(check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown *If yes, describe where:* _____ *If yes, list dates:* _____

17. In the 10 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?
(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? (check all that apply) 1 ☐ Sterile 1 ☐ Distilled 1 ☐ Bottled 1 ☐ Tap 1 ☐ Other 1 ☐ Unknown

18. In the 10 days before onset, did the patient 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)	TYPE OF EXPOSURE (CHECK ONE)	NAME OF FACILITY	IS THIS FACILITY ALSO A TRANSPLANT CENTER?	REASON FOR VISIT	CITY	STATE	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					
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					

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State Health Dept. Case No.: _____

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

1 ☐ **Definitely:** Patient was hospitalized or a resident of a long term care facility for the entire 10 days prior to onset

2 ☐ **No:** No exposure to a healthcare facility in the 10 days prior to onset

3 ☐ **Possibly:** Patient had exposure to a healthcare facility for a portion of the 10 days prior to onset

8 ☐ **Other (specify)** _____

9 ☐ **Unknown**

20. **In the 10 days before onset,** did the patient visit or stay in an assisted living facility or senior living facility? (check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

TYPE OF FACILITY	TYPE OF EXPOSURE	NAME OF FACILITY	CITY	STATE	DATE OF VISIT	
					START DATE	END DATE
1 ☐ Assisted Living	1 ☐ Resident 2 ☐ Visitor or Volunteer 3 ☐ Employee					
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

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

PLEASE CHECK ALL METHODS OF DIAGNOSIS WHICH APPLY:

1 ☐ CONFIRMED CASE

1 ☐ **Urine Antigen Positive:** *If yes,*

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

2 ☐ **Culture Positive:** *If yes,*

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

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

Species: _____ Serogroup: _____

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

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

Convalescent titer: _____ Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

2 ☐ SUSPECT CASE

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

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

Convalescent titer: _____ Date Collected: ☐☐ (Mo.) ☐☐ (Day) ☐☐☐☐ (Year)

Species: _____ Serogroup: _____

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

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

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

Species: _____ Serogroup: _____

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

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

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

Species: _____ Serogroup: _____

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

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