## Legionnaires’ Disease Medical Record Abstraction Form Template

Abstractor name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information source** *<Check all that apply>*

Hospital chart  Electronic medical records  Staff interview  Patient interview

Emergency department or clinic chart  Proxy interview

Other *<If other, specify>*:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Medical record number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Healthcare facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:  M  F

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age (on admission or symptom onset): \_\_\_\_\_\_\_\_\_\_

Race/Ethnicity *<Check all that apply>*:

American Indian/Alaska Native  Native Hawaiian or other Pacific Islander

Asian  White

Black or African American  Unknown

Ethnicity:

Hispanic/Latino  Not Hispanic/Latino  Unknown

Type of Residence:

Home  Long-term care facility  Senior-living facility  Assisted living facility

Other *<If other, specify>*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the patient’s outcome?  Recovered  Still ill  Died  Unknown

**Proxy contact information** *<List proxy contact information if patient is unable to be interviewed or has died.>*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt. phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Legionella*-specific testing**

Respiratory specimen collected and processed for *Legionella*-specific culture?

Yes  No  Unknown

If yes, specimen type (e.g., expectorated sputum, BAL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, respiratory specimen collected for any culture?

Yes  No  Unknown

If yes, specimen type (e.g., expectorated sputum, BAL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urine specimen collected for *Legionella* urinary antigen testing?

Yes  No  Unknown

If yes, date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCR testing for *Legionella*?

Yes  No  Unknown

If yes, specimen type (e.g., expectorated sputum, BAL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acute (initial) serum sample collected for *Legionella* serologic testing?

Yes  No  Unknown

If yes, date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of assay (e.g., Lp1 only, Lp1-6 pooled antigen, *Legionella* spp. pooled antigen): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Convalescent serum samples collected for *Legionella* serologic testing?

Yes  No  Unknown

Date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other *Legionella* testing?

Yes  No  Unknown

Date collected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signs and symptoms**

*<The following sections apply to the patient’s hospitalization or medical care received for the treatment of symptoms compatible with Legionnaires’ disease (or Pontiac fever). Check all that apply.>*

Shortness of breath  Cough

Hemoptysis (coughing up blood)  Fever >100.4°F

Diarrhea (3 stools/24 h)  Nausea or vomiting

Altered mental status (confusion)  Myalgia (body aches)

Malaise (discomfort)  Headache

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*<If the patient did not have prior respiratory symptoms, choose the onset date of cough or shortness of breath, whichever occurs first. Otherwise, use the earliest date when other symptoms compatible with Legionnaires’ disease began. For Pontiac fever cases, use the earliest date when fever, myalgia (body aches) or headache began.>*

Date of earliest symptom onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Radiographic findings**

*<Review any radiographic findings 14 days after onset of symptoms above. If multiple chest images are available, report the first for which evidence of pneumonia is noted.>*

Evidence of pneumonia on radiographic exam?

Yes  No  Unknown

If yes,  Chest x-ray  CT scan Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Result: *<Check all that apply from radiology report>*

Pneumonia/bronchopneumonia  Pleural effusion

Consolidation  Pneumonitis

Lobar (NOT interstitial) infiltrate  Pulmonary edema

Single lobar  Interstitial infiltrate

Multiple lobar infiltrate (unilateral)  Empyema

Multiple lobar infiltrate (bilateral)  ARDS (acute respiratory distress syndrome)

Air space/alveolar density/opacity/disease  Normal

Atelectasis  Cannot rule out pneumonia

Cavitation  Report not available

Other (specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[**Case classification**](https://www.cdc.gov/legionella/health-depts/surv-reporting/case-definitions.html)

Legionnaires’ disease  Pontiac fever

Extrapulmonary legionellosis (specify site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Confirmed case  Suspect case  Probable case

**Medical history**

COPD/emphysema/chronic lung disease

Asthma

Diabetes

Congestive heart failure

Chronic renal insufficiency (CRI/CKD) or end-stage renal disease (ESRD)

Cirrhosis/liver disease

History of stroke/CVA

Dementia

HIV/AIDS (CD4 count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other immunosuppressive condition (e.g., immunoglobulin deficiency, splenectomy, sickle cell anemia) (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Solid organ transplant (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Bone marrow transplant (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Cancer, hematologic (Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Cancer, solid organ (Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

History of chemotherapy (Date of last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

History of radiation (Date of last treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other immunosuppressive therapy (e.g., systemic steroids, anti-rejection medications, biologic therapy) (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Dysphagia, aspiration risk

History of pneumonia in prior year (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other (Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

| Behaviors | *<Check one:>* | | Quantity per day  (packs or drinks) | Duration (years) |
| --- | --- | --- | --- | --- |
| Yes | No |
| Current smoker? |  |  |  |  |
| Former smoker? |  |  |  |  |
| Consume alcohol? |  |  |  |  |

History of other substance abuse:

Yes  No  Unknown

If yes, specify substance(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Antibiotic therapy**

*<Check all that apply during or preceding treatment for Legionnaires’ disease>*

| Therapy | Dose | Route | Start date | End date | Continued as outpatient?  *<Check if yes>* |
| --- | --- | --- | --- | --- | --- |
| Levofloxacin (Levaquin) |  |  |  |  |  |
| Moxifloxacin |  |  |  |  |  |
| Ciprofloxacin (Cipro) |  |  |  |  |  |
| Azithromycin (Zithromax) |  |  |  |  |  |
| Erythromycin |  |  |  |  |  |
| Ceftriaxone (Rocephin) |  |  |  |  |  |
| Rifampin |  |  |  |  |  |
| Rifapentine |  |  |  |  |  |
| Linezolid |  |  |  |  |  |
| Tetracycline |  |  |  |  |  |
| Doxycycline |  |  |  |  |  |
| Vancomycin |  |  |  |  |  |
| Piperacillin-tazobactam (Zosyn) |  |  |  |  |  |
| Other (specify): \_\_\_\_\_\_\_\_ |  |  |  |  |  |
| Other (specify): \_\_\_\_\_\_\_\_ |  |  |  |  |  |

**Clinical outcomes**

Hospitalized: ICU stay:

Yes  No  Unknown  Yes  No  Unknown

If yes, dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, intubated?  Yes  No  Unknown

Disposition:

Still hospitalized

Discharged home (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Transferred to another facility (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Deceased (Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Unknown

Discharge diagnosis:

Legionnaires’ disease

Pneumonia

If yes, etiology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab test(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*<The following sections apply to the patient’s healthcare exposures before the onset of symptoms compatible with Legionnaires’ disease (or Pontiac fever).>*

**Exposure information**

*<Important: Use a calendar to calculate exposure period! Start at the date of earliest symptom onset documented above and count backwards 14 days. See example below.>*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sun** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** |
|  |  | 1 | 2 | 3  **1st day of exposure period** | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17  **Date of onset** | 18 | 19 |

*<Document exposure period here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.>*

*<Document the patient’s healthcare exposures for each day during his/her exposure period, starting with the first day listed above. Additional details regarding specific location(s) will be addressed below.>*

|  |  |  |  |
| --- | --- | --- | --- |
| # | Date(s) | Type of healthcare exposure\* | Name/location of healthcare facility |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

\* *<Specify whether inpatient, outpatient, resident, visitor, volunteer or employee>*

[Case classification](https://www.cdc.gov/legionella/health-depts/surv-reporting/case-definitions.html) (according to surveillance or outbreak case definition):

Presumptive healthcare-associated  Possible healthcare-associated  Not healthcare-associated

*<If not healthcare-associated, END HERE. Otherwise, continue.>*

**Exposure information for possible exposures in inpatient healthcare settings**

*<Beginning the first day of the exposure period, complete the following sections for each inpatient healthcare exposure in the 14 days before date of symptom onset, duplicating the template as needed. If the patient had only outpatient or other exposures, skip to the appropriate section below.>*

Healthcare exposure #: \_\_\_\_\_\_\_\_\_\_ Facility name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admission date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief complaint/reason for admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*<List specific locations, dates, and reasons for each inpatient location at this facility during exposure period.>*

| Building | Room # | Date(s) | Reason |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Was the patient ambulatory?  Yes  No  Unknown

If yes, did the patient leave the building during hospitalization?  Yes  No  Unknown

If yes, indicate locations and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the patient shower?  Yes  No  Unknown

If yes, list applicable building/rooms:

Was the patient intubated?  Yes  No  Unknown

If yes, list applicable building/rooms:

Did the patient use respiratory therapy equipment?  Yes  No  Unknown

If yes, list applicable building/rooms:

Did the patient use a therapy tub?  Yes  No  Unknown

If yes, list applicable building/rooms:

Did the patient receive wound care?  Yes  No  Unknown

If yes, list applicable building/rooms:

Did the patient receive ice from a healthcare facility’s ice machine?  Yes  No  Unknown

If yes, list applicable building/areas:

Comments:

**Exposure information for possible exposures in outpatient healthcare settings**

*<Beginning the first day of the exposure period, complete this section for each outpatient visit in the 14 days before date of symptom onset, duplicating the template as needed. If the patient had other exposures, skip to the “Other Exposures” section below.>*

*<List specific locations, dates, and reasons for each outpatient healthcare visit during exposure period.>*

| Clinic/building | Address | Room # | Date(s) of visit | Reason for visit |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Other exposures**

Did the patient have any other exposure to the facility in the 14 days before date of symptom onset?

Yes  No  Unknown

If yes, please note each possible exposure, being as specific as possible with locations and dates: