

Patient's Name (Last, First, MI) _____ Phone: _____ Hospital: 58237-9

Address (Number, Street, Apt No., City PID-11.3, State PID-11.4, ZIP PID-11.5): _____

Patient Chart No: _____ ***PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC***

National Center for Immunization and Respiratory Diseases

LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY LEGIONELLA SPECIES)

U.S. Department of Health and Human Services

Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, 30329

CDC Use Only
Case No.: _____

GENERIC MMG

Legionellosis_V1_0_F_20240614(4)_MMG

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 1. State health dept. case no.: 77993-4 | | 2. Reporting state: 77966-0 | | 3. City of residence: _____ | | 4. County of residence: 77983-5 | | 5. State of residence: PID-11.4 | |
| 6. Industry: 85078-4 | | 7. Occupation: 85658-3 | | 8a. Date of birth: PID-7 (mm/dd/yyyy) _____ | | 8b. Age: _____ <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years 77998-3 OBX-6 for 77998-3 | | 9. Sex: PID-8 <input type="radio"/> Male <input type="radio"/> Female | |
| 10. Ethnicity PID-22 <input type="radio"/> Hispanic/Latino <input type="radio"/> Not Hispanic/Latino <input type="radio"/> Unknown | | 11. Race (check all that apply): PID-10 <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American | | <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown | | 12. Diagnosis INV1059 <input type="radio"/> Legionnaires' disease (pneumonia, clinical or x-ray diagnosed) <input type="radio"/> Pontiac fever (fever and myalgia without pneumonia) <input type="radio"/> Extrapulmonary legionellosis (specify location): _____ | | | |
| 13. Date of symptom onset of legionellosis (mm/dd/yyyy): 11368-8 | | | | 14. Date of first report to public health at any level: (mm/dd/yyyy): 77970-2 | | | | | |
| 15. Was the patient hospitalized during treatment for legionellosis? 77974-4 <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | | If yes, date of admission: (mm/dd/yyyy) 8656-1 Hospital name: 58237-9 City: INV1060 State: INV1061 | | | 16. Outcome of illness: <input type="radio"/> Survived 77978-5 <input type="radio"/> Died <input type="radio"/> Still ill <input type="radio"/> Unknown | | | |
| 17. In the 14 days before onset did the patient spend any nights away from home (excluding healthcare settings)? INV1062 <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, please complete the following information: | | | | | | | | | |
| Name of accommodation 1: TRAVEL 42 | | | | | | | | | |
| Street address: TRAVEL 43 | | | Room number: TRAVEL 47 | | | | | | |
| City: TRAVEL 45 | | State: TRAVEL 44 | | ZIP: TRAVEL 51 | | | | | |
| Country: TRAVEL 46 | | Date of arrival: TRAVEL 49 | | Date of departure: TRAVEL 50 | | | | | |
| Comments about travel: TRAVEL 48 | | | | | | | | | |
| Name of accommodation 2: TRAVEL 42 | | | | | | | | | |
| Street address: TRAVEL 43 | | | Room number: TRAVEL 47 | | | | | | |
| City: TRAVEL 45 | | State: TRAVEL 44 | | ZIP: TRAVEL 51 | | | | | |
| Country: TRAVEL 46 | | Date of arrival: TRAVEL 49 | | Date of departure: TRAVEL 50 | | | | | |
| Comments about travel: TRAVEL 48 | | | | | | | | | |
| *To add additional accommodations, see Page 7 | | | | | | | | | |
| 18. In the 14 days before onset, did the patient visit or stay in a healthcare setting (e.g., hospital, long-term care/rehab/skilled nursing facility, clinic)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown INV1063 | | | | | | | | | |
| 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 | | | | | | | | | |

If yes, please complete the following information:

| | | |
|---|---|--|
| Name of healthcare facility 1: 76696-4 | | |
| Type of healthcare setting/facility: 81267-7 | Type of exposure: INV1064 | Is this facility also a transplant center? INV1065 |
| <input type="radio"/> Hospital <input type="radio"/> Other, specify: _____ <input type="radio"/> Long term care _____ <input type="radio"/> Clinic <input type="radio"/> Unknown | <input type="radio"/> Inpatient <input type="radio"/> Unknown <input type="radio"/> Outpatient <input type="radio"/> Other, specify: _____ <input type="radio"/> Visitor or volunteer _____ <input type="radio"/> Employee | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Street address: 65833-6 | City: 65647-0 | |
| State: 68488-6 | ZIP: 65648-8 | Reason for visit: INV1066 |
| Date of arrival: INV1067 | Date of departure: INV1068 | Did the healthcare facility have in place a water management program to reduce the risk of <i>Legionella</i> growth and spread? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown INV1070 |
| Comments about healthcare facility: INV1069 | | |

| | | |
|---|---|--|
| Name of healthcare facility 2: 76696-4 | | |
| Type of healthcare setting/facility: 81267-7 | Type of exposure: INV1064 | Is this facility also a transplant center? INV1065 |
| <input type="radio"/> Hospital <input type="radio"/> Other, specify: _____ <input type="radio"/> Long term care _____ <input type="radio"/> Clinic <input type="radio"/> Unknown | <input type="radio"/> Inpatient <input type="radio"/> Unknown <input type="radio"/> Outpatient <input type="radio"/> Other, specify: _____ <input type="radio"/> Visitor or volunteer _____ <input type="radio"/> Employee | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| Street address: 65833-6 | City: 65647-0 | |
| State: 68488-6 | ZIP: 65648-8 | Reason for visit: INV1066 |
| Date of arrival: INV1067 | Date of departure: INV1068 | Did the healthcare facility have in place a water management program to reduce the risk of <i>Legionella</i> growth and spread? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown INV1070 |
| Comments about healthcare facility: INV1069 | | |

19. Was this case associated with a healthcare exposure: INV1071

Presumptive: Patient had 10 or more days of continuous stay at a healthcare facility during the 14 days before onset of symptoms

Possible: Patient had exposure to an assisted/senior living facility for a portion of the entire 14 days prior to onset

No: No exposure to a healthcare facility in the 14 days prior to onset

Unknown

20. In the 14 days before onset, did patient visit or stay in an assisted living facility or senior living facility? Assisted/senior living facilities do not provide skilled nursing or medical care. INV1072

Yes No Unknown

If yes, please complete the following information:

Type of setting/facility: Assisted living facility Senior living facility Unknown INV1074

Name of assisted/senior living facility 1: INV1076

Type of exposure: Resident Visitor or volunteer Employee Other (specify): INV1075 Unknown

Street address: INV1077

City: INV1078 State: INV1079 ZIP: INV1080

Date of arrival: INV1081 Date of departure: INV1082

Comments about assisted or senior living facility: INV1083

Did the assisted/senior living facility have in place a water management program to reduce the risk of *Legionella* growth and spread? INV1084

Yes No Unknown

21. Was this case associated with an assisted or senior living facility? INV1073

Presumptive: Patient had 10 or more days of continuous stay at a healthcare facility during the 14 days before onset of symptoms

Possible: Patient had exposure to an assisted/senior living facility for a portion of the entire 14 days prior to onset

No: No exposure to an assisted/senior living facility in the 14 days prior to onset

Unknown

| | |
|--|---|
| 22. Was this case associated with a known outbreak or possible cluster? 77980-1 | 23. If this case was associated with an outbreak reported to NORS (National Outbreak Reporting System), what is the CDC assigned NORS outbreak ID? INV883 |
| <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| If yes, specify name of facility, city, and state of outbreak: Name of facility: _____ City: _____ State: _____ | |

24. Laboratory diagnostic tests

| Tests <input type="text" value="INV290"/> | Date collected mm/dd/yyyy <input type="text" value="68963-8"/> | Specimen type <input type="text" value="66746-9"/> | Results <input type="text" value="INV291"/> |
|--|--|--|---|
| Urinary antigen test (UAT) | <input type="text" value="68963-8"/> | Urine | <input type="radio"/> Positive <input type="radio"/> Indeterminant <input type="radio"/> Negative <input type="radio"/> Not performed <input type="radio"/> Unknown |
| Culture | <input type="text"/> | <input type="radio"/> Lower respiratory secretions (e.g., sputum, BAL) <input type="radio"/> Other, specify: <input type="text"/> | <input type="radio"/> Positive <input type="radio"/> Indeterminant <input type="radio"/> Negative <input type="radio"/> Not performed <input type="radio"/> Unknown |
| Nucleic acid assay (e.g., PCR) | <input type="text"/> | <input type="radio"/> Lower respiratory secretions (e.g., sputum, BAL) <input type="radio"/> Other, specify: <input type="text"/> | <input type="radio"/> Positive <input type="radio"/> Indeterminant <input type="radio"/> Negative <input type="radio"/> Not performed <input type="radio"/> Unknown |
| Direct fluorescent antibody (DFA) or immunohistochemistry (IHC) | <input type="text"/> | <input type="radio"/> Lower respiratory secretions (e.g., sputum, BAL) <input type="radio"/> Other, specify: <input type="text"/> | <input type="radio"/> Positive <input type="radio"/> Indeterminant <input type="radio"/> Negative <input type="radio"/> Not performed <input type="radio"/> Unknown |

25. If culture, nucleic acid assay (e.g., PCR) or DFA/INC were performed, specify species and/or serogroup identified:

Species:

Serogroup:

26. Serologic tests:

| Antibody titer test <input type="text" value="LAB653"/> | <input type="text" value="68963-8"/> Date collected | Quantitative titer view <input type="text" value="LAB628"/> | Results <input type="text" value="INV291"/> |
|--|---|---|--|
| Antibody titer to <i>Legionella pneumophila</i> serogroup 1 | Acute: <input type="text"/> Convalescent: <input type="text"/> | Acute: <input type="text"/> Convalescent: <input type="text"/> | <input type="radio"/> Positive (4X or greater rise in titer) <input type="radio"/> Indeterminant <input type="radio"/> Negative <input type="radio"/> Not performed <input type="radio"/> Unknown |
| Antibody titer OTHER THAN <i>Legionella pneumophila</i> serogroup 1 or to multiple species or serogroups of <i>Legionella</i> using pooled antigen | Acute: <input type="text"/> Convalescent: <input type="text"/> | Acute: <input type="text"/> Convalescent: <input type="text"/> | <input type="radio"/> Positive (4X or greater rise in titer) <input type="radio"/> Indeterminant <input type="radio"/> Negative <input type="radio"/> Not performed <input type="radio"/> Unknown |

27. Was specimen sent to CDC for testing?

- Yes
- No
- Unknown

Date specimen sent to CDC for testing:

28. Case status:

- Confirmed
- Suspect
- Probable
- Not a case

If probable, indicate epidemiological link: _____

29. In the 14 days before onset, was the patient exposed to any of the following? *If yes, indicate the location and dates.* INV1085

| Potential exposure(s) INV1085 | Yes, No, Unknown INV1086 | Location (facility name, city, state) INV1087 | Date(s) INV1088 |
|--|--|---|-----------------|
| Shower away from home | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| In or near a hot tube | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Near a decorative water fountain or water feature | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Near a mister | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Near a sprinkler | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Recreational water park | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Near some other water aerosolizing device: _____ | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Attend a convention, reception, conference, or other public gathering | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Visit or live in a congregate living facility (e.g., correctional facilities, shelters, dormitories, etc.) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Visit an area with large buildings (e.g., shopping centers, high rise complexes, etc., that may have a cooling tower(s)) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Construction, remodeling near home or place visited | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Work with water device/system maintenance (e.g., cooling towers, plumbing, hot tub) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Work in water-related leisure (e.g., hotels, cruise ships, water parks) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Industrial/manufacturing plant with a water spray cooling system or processes involving spraying water | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Commercial or long-haul truck driving | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Work in commercial kitchen | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Work in custodial services (e.g., housekeeping, janitorial) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Work in construction (e.g., spraying water, demolition, refurbishing) | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Work at wastewater treatment plant | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |
| Work in another occupation involving water exposures: _____ | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | |

30. In the 14 days before onset, did the patient use respiratory therapy equipment* (e.g., nebulizer, CPAP, BiPAP) for treatment of sleep apnea, COPD, asthma, or any other reason? INV1086

Yes No Unknown

If yes to respiratory therapy equipment, does this device use a humidifier?* INV1089

Yes No Unknown

****If yes to humidifier, what type of water is used in the device?** INV1090

(check all that apply)

- Sterile Bottled Other
 Distilled Tap Unknown

31. In the 14 days before onset, did the patient take a cruise?

Yes No Unknown 473085002

If yes,

| | |
|------------------------------------|--|
| Name of cruise line: TRAVEL52 | Name of ship: TRAVEL53 |
| Cruise departure city: TRAVEL54 | Cruise departure state: TRAVEL55 |
| Cruise departure country: TRAVEL56 | Cruise departure date: TRAVEL57 |
| Cruise return city: TRAVEL58 | Cruise return state: TRAVEL59 |
| Cruise return country: TRAVEL60 | Cruise return date: TRAVEL61 Cabin number TRAVEL62 |

Ports of call:

| City | State | Country | Date |
|----------|----------|----------|----------|
| TRAVEL63 | TRAVEL64 | TRAVEL66 | TRAVEL65 |
| | | | |
| | | | |
| | | | |
| | | | |

32. Did the patient have any underlying conditions or prior illnesses?

Yes No Unknown INV235

If yes, indicate whether the patient has each of the following underlying conditions

| Condition | INV236 | INV662 | Patient history | Condition | INV236 | Patient history | INV662 |
|--------------------------------|--------|--|-----------------|--------------------------------|--------|--|--------|
| AIDS | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Kidney disease | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Alcohol abuse (current/past) | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Leukemia | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Asthma | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Multiple myeloma | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Blood cancer | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Multiple sclerosis | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Bone marrow transplant | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Myocardial infarction | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Broken skin | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Nephrotic syndrome | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Cancer | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Neuromuscular disorder | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Cancer treatment | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Obesity | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Cerebrospinal fluid leak | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Paralysis | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Cerebrovascular accident | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Parkinson's disease | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Chronic respiratory disease | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Peptic ulcer | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Chronic hepatitis C | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Peripheral neuropathy | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Cirrhosis/liver failure | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Peripheral vascular disease | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Cochlear prosthesis | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Premature birth | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Complement deficiency disease | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Renal failure/dialysis | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Congestive heart failure | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Seizure disorder | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Connective tissue disorder | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Sickle cell trait | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Coronary arteriosclerosis | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Smoker - current | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Corticosteroids | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Smoker - former | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Current chronic dialysis | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Solid organ malignancy | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Deafness/profound hearing loss | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Solid organ transplant | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Dementia | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Spleen missing | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Diabetes mellitus | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Splenectomy/asplenia | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Emphysema/COPD | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Systemic lupus erythematosus | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| HIV infection | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Trouble swallowing (dysphagia) | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Hodgkin's disease (clinical) | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Other (specify) | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | |
| Immunoglobulin deficiency | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | | | | |
| Immunosuppressive therapy | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | | | | |
| Intravenous drug user | | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown | | Unknown | | <input type="radio"/> Yes <input type="radio"/> No | |

33. Was the patient or proxy interviewed by public health?

Yes No Unknown

Comments: 77999-1

Interviewer's name: _____

Affiliation: _____ Phone: _____

State health dept. official who reviewed this report: _____

Title: _____ Phone: _____

Local Health Dept. please submit this document to:

State/DHD/SSS via your communicable disease clerk

State Health Dept. return completed form to: travellegionella@cdc.gov

APPENDIX (Additional Facilities)

(Additional accommodations – continued from page 1)

Name of accommodation 3: _____

Street address: _____ Room number: _____

City: _____ State: _____ ZIP: _____

Country: _____ Date of arrival: _____ Date of departure: _____

Comments about travel: _____

Name of accommodation 4: _____

Street address: _____ Room number: _____

City: _____ State: _____ ZIP: _____

Country: _____ Date of arrival: _____ Date of departure: _____

Comments about travel: _____

(Additional healthcare facilities – continued from page 2)

Name of healthcare facility: 3 _____

| | | |
|---|---|--|
| Type of healthcare setting/facility: | Type of exposure: | Is this facility also a transplant center? |
| <input type="radio"/> Hospital <input type="radio"/> Long-term care <input type="radio"/> Clinic <input type="radio"/> Unknown | <input type="radio"/> Inpatient <input type="radio"/> Outpatient <input type="radio"/> Visitor or volunteer <input type="radio"/> Employee | <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown |
| <input type="radio"/> Other, specify: _____ | <input type="radio"/> Unknown <input type="radio"/> Other, specify: _____ | |

Street address: _____ City: _____

State: _____ ZIP: _____ Reason for visit: _____

Date of arrival: _____ Date of departure: _____

Comments about travel: _____

Did the healthcare facility have in place a water management program to reduce the risk of *Legionella* growth and spread? Yes No Unknown

(Additional assisted/senior living facilities – continued from page 2)

If yes, what type? Assisted living facility Senior living facility Unknown

Name of assisted/senior living facility 2: _____

Type of exposure: Resident Visitor or volunteer Employee Other, specify _____ Unknown

Street address: _____

City: _____ State: _____ ZIP: _____

Date of arrival: _____ Date of departure: _____

Comments about assisted or senior living facility: _____

Did the assisted/senior living facility have in place a water management program to reduce the risk of *Legionella* growth and spread?