CDC National Center for Immunization and Respiratory Diseases

LEGIONELLOSIS CASE REPORT

(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-113
   4. State of Residence: PID-114
   5. Occupation: 85658-3

6a. Date of Birth: PID-7
   Mo. □ Day □ Year □
   6b. Age: PID-8
   7. Sex: PID-6
   1 □ Male
   8. Ethnicity: PID-22
   1 □ Hispanic/Latino
   9 □ Unknown
   2 □ Female
   9. Race: (check all that apply)
   1 □ American Indian/ Alaska Native
   2 □ Native Hawaiian or Other Pacific Islander
   3 □ Asian
   4 □ White
   5 □ Black or African American
   6 □ Other:

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? 77974-4
    1 □ Yes
    2 □ No
    9 □ Unknown

14. Outcome of illness:
    1 □ Survived
    2 □ Died
    3 □ Still ill
    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)  □ Yes*  □ No 9 □ Unknown

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

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

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) □ Yes  □ No 9 □ Unknown

18. In the 14 days before onset, INV1063 did the patient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?
    (check one) □ Yes  □ No 9 □ Unknown

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.
19. Was this case associated with a healthcare exposure: (check one)
☐ Presumptive: Patient had 10 or more days of continuous stay at a healthcare facility during the 14 days before onset of symptoms.
☐ Possibly: Patient had exposure to a healthcare facility for a portion of the 14 days prior to onset
☐ No: No exposure to a healthcare facility in the 14 days prior to onset
☐ Other (specify) ____________________________________________

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

<table>
<thead>
<tr>
<th>TYPE OF FACILITY (INV1074)</th>
<th>TYPE OF EXPOSURE (INV1075)</th>
<th>NAME OF FACILITY (INV1076)</th>
<th>CITY (INV1078)</th>
<th>DATE OF VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ☐ Assisted Living</td>
<td>1 ☐ Resident</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 ☐ Senior Living (Includes retirement homes without skilled nursing or personal care)</td>
<td>1 ☐ Resident</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

LABORATORY DATA

1 ☐ Urinary Antigen Positive: If yes, LAB693

Date Collected: [ ] [ ] [ ] [ ] [ ]

Species: LAB278

2 ☐ Culture Positive: If yes, LAB690

Date Collected: [ ] [ ] [ ] [ ] [ ]

Site: [6746-9] 1 lung biopsy 2 respiratory secretions (e.g., sputum, BAL) 3 pleural fluid 4 blood 8 other (specify) __________________________

Species: LAB278

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

Initial (acute) titer: ________ Date Collected: [ ] [ ] [ ] [ ] [ ]

Species: LAB278

Convalescent titer: ________ Date Collected: [ ] [ ] [ ] [ ] [ ]

Species: LAB278

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, LAB715

Initial (acute) titer: ________ Date Collected: [ ] [ ] [ ] [ ] [ ]

Species: LAB278

Convalescent titer: ________ Date Collected: [ ] [ ] [ ] [ ] [ ]

Species: LAB278

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

Date Collected: [ ] [ ] [ ] [ ] [ ]

Site: [6746-9] 1 lung biopsy 2 respiratory secretions (e.g., sputum, BAL) 3 pleural fluid 4 blood 8 other (specify) __________________________

Species: LAB278

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

Date Collected: [ ] [ ] [ ] [ ] [ ]

Site: [6746-9] 1 lung biopsy 2 respiratory secretions (e.g., sputum, BAL) 3 pleural fluid 4 blood 8 other (specify) __________________________

Species: LAB278

3 ☐ PROBABLE CASE Indicate epidemiologic link in notes field

INTERVIEWER IDENTIFICATION

Interviewer’s Name: ____________________________

State Health Dept. Official who reviewed this report: ____________________________

Affiliation: ____________________________

Title: ____________________________

Telephone No.: ____________________________

Telephone No.: ____________________________

COMMENTS

Local Health Dept. Please submit this document to:

State Health Dept. Official who reviewed this report:

Local Health Dept. Please submit this document to:

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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LAB714

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