

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. 0920-0009



CDC • National Center for Immunization and Respiratory Diseases

LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY LEGIONELLA SPECIES)



Department of Health & Human Services
Centers for Disease Control and Prevention (CDC), Atlanta, Georgia, 30333
<http://www.cdc.gov/legionella/index.htm>

Case No.:
(CDC use only)

1. State Health Dept. Case No.:	2. Reporting State: <input type="text"/> <input type="text"/>	3. County of Residence:	4. State of Residence: <input type="text"/> <input type="text"/>	5. Occupation:
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6a. Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year	6b. Age: <input type="text"/> <input type="text"/> 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Years	7. Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	8. Ethnicity: 1 <input type="checkbox"/> Hispanic/Latino 2 <input type="checkbox"/> Not Hispanic/Latino 9 <input type="checkbox"/> Unknown	9. Race: (check all that apply) 1 <input type="checkbox"/> American Indian/ Alaska Native 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Unknown
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10. Diagnosis: (check one) 1 <input type="checkbox"/> Legionnaires' Disease (pneumonia, clinical or X-ray diagnosed) 2 <input type="checkbox"/> Pontiac Fever (fever and myalgia without pneumonia) 8 <input type="checkbox"/> Other (e.g., endocarditis, wound infection): _____	11. Date of symptom onset of legionellosis: <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year	12. Date of first report to public health at any level: <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year
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13. Was the patient hospitalized during treatment for legionellosis? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If yes, date of admission: <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year Hospital name: _____ City, State: _____	14. Outcome of illness: 1 <input type="checkbox"/> Survived 3 <input type="checkbox"/> Still ill 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown
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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 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Long term care 3 <input type="checkbox"/> Clinic 8 <input type="checkbox"/> Other: _____	1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> Visitor or volunteer 4 <input type="checkbox"/> Employee		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown					
1 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Long term care 3 <input type="checkbox"/> Clinic 8 <input type="checkbox"/> Other: _____	1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> Visitor or volunteer 4 <input type="checkbox"/> Employee		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> 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)

- 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

State Health Dept. Case No.: _____

- 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 <input type="checkbox"/> Assisted Living	1 <input type="checkbox"/> Resident 2 <input type="checkbox"/> Visitor or Volunteer 3 <input type="checkbox"/> Employee					
2 <input type="checkbox"/> Senior Living (Includes retirement homes <u>without</u> skilled nursing or personal care)	1 <input type="checkbox"/> Resident 2 <input type="checkbox"/> Visitor or Volunteer 3 <input type="checkbox"/> 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: _____

Affiliation: _____

Telephone No.: _____

State Health Dept. Official who reviewed this report: _____

Title: _____

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 C25
 Office of Infectious Diseases
 Centers for Disease Control and Prevention
 1600 Clifton Rd. NE, Atlanta, GA 30333**