

# Legionellosis

## PATIENT DEMOGRAPHICS

Name (last, first): _____	Birth date: __/__/____ Age: _____
Address (mailing): _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
Address physical): _____	Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
City/State/Zip: _____	Race: (mark all that apply)
Phone (home): _____ Phone (work/cell) : _____	<input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. <input type="checkbox"/> Asian
Occupation _____	<input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Am. Ind/AK Native
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other	<input type="checkbox"/> Other <input type="checkbox"/> Unk
Name: _____ Phone: _____	

## INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Entered in WVEDSS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Investigation Start Date: __/__/____	Case Classification:
Earliest date reported to LHD: __/__/____	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect
Earliest date reported to State: __/__/____	<input type="checkbox"/> Not a case <input type="checkbox"/> Unknown

## REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: <input type="checkbox"/> Laboratory <input type="checkbox"/> Hospital <input type="checkbox"/> Private Provider <input type="checkbox"/> Public Health Agency <input type="checkbox"/> Other _____
Reporter Name: _____ Reporter Phone : _____
Primary HCP Name: _____ Primary HCP Phone: _____

## CLINICAL

Onset date: __/__/____	Diagnosis date: __/__/____	Recovery date: __/__/____
<b>Clinical Findings</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legionnaires' Disease (Pneumonia, x-ray diagnosed) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pontiac Fever (Fever, myalgia without pneumonia) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Admitted to intensive care unit <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mechanical ventilation or intubation required  <b>Predisposing Factors</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Smokes tobacco <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Immunosuppressive therapy or disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic diabetes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Underlying illness, Specify: _____	<b>Signs and Symptoms</b> <b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____  <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalized for this illness Hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____ <b>Death</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Died due to this illness Date of death: __/__/____	<b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Myalgia (muscle pain) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest Pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Malaise <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea

## LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

Specimen source: _____	Collection date: __/__/____
<b>Y N U</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legionella culture (normally sterile site) Species _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> L. pneumophilla serogroup 1 antigen detected in urine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> L. pneumophilla serogroup 1 serum antibody titer with >= 4 fold rise (acute and convalescent serum pair) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Titer to Legionella species/serogroups other than L. pneumophilla serogroup 1, >= 4 fold rise <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legionella antigen or organism detected by DFA, Immunohistochemistry, or other method in respiratory secretions <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legionella species detected by validated nucleic acid assay	

## INFECTION TIMELINE

**Instructions:**

Enter onset date in grey box. Count backward to determine probable exposure period

Days from onset

Calendar dates:

Exposure period

-14 (Max Incubation)	-1 (Min Incubation)
_ / _ / _	_ / _ / _

Onset date



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## EPIDEMIOLOGIC EXPOSURES

### Travel History

**Y N U** In the 10 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?

If yes, complete table below:

Accommodation name	Address, city, state, zip, country	Room #	Arrival date	Departure date

### Other Exposure History

**Y N U** In the 10 days before onset did the patient:

- Get in or spend time near a whirlpool spa/ hot tub /jacuzzi? Location: \_\_\_\_\_
- Use a nebulizer, CPAP, BiPAP of any other respiratory therapy device for the treatment of sleep apnea, COPD or asthma?  
does this device have a humidifier? What type of water is used? Sterile / distilled /bottled /tap / well/ other
- Have exposures to aerosolized water (e.g. fountains, misters, sprinklers)? Location: \_\_\_\_\_
- Have recreational water exposures (e.g., lakes, rivers, pools, spray pads) Location: \_\_\_\_\_
- Have exposures to soil (gardening, potting soil, excavation, etc.)? Location: \_\_\_\_\_
- Have exposures to remodeling or construction near home or work? Location: \_\_\_\_\_

### Healthcare Associated Exposures

In the 10 days before onset, did the patient visit or stay at a healthcare setting (e.g., hospital, rehab facility, clinic, dental office)? If yes, complete table below:

Was the healthcare facility a transplant center? (if more than one facility was visited, please list all transplant centers)

**Type of setting:** H = Hospital, R = Rehab, C = Clinic, D = Dental O = Other

**Type of exposure:** IP = Inpatient, OP = Outpatient, R = Resident, Vi = Visitor, E = Employee, Vo = Volunteer

**Type of facility:** NH = Nursing home (skilled personal care), AL = Assisted living facility, SL = Senior living facility (no skilled personal care)

Type of setting H R C D O	Type of exposure IP OP Vi E Vo	Name of facility	Reason for visit	City, state	Dates
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				

**Y N U** In the 10 days before onset, did the patient visit or stay at a nursing home, assisted living facility or senior living facility?

If yes, complete table below:

Type of facility NH AL SL	Type of exposure R Vi E Vo	Name of facility	City, state	Dates
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

**Was the case hospital related (nosocomial)? specify below:**

- Not nosocomial: No inpatient or outpatient hospital visits in the 10 days prior to onset of symptoms
- Possibly nosocomial: Patient hospitalized 2-9 days before onset of legionella infection
- Definitely nosocomial: Patient hospitalized continuously for >= 10 days before onset of legionella infection
- Other (Specify) \_\_\_\_\_
- Unknown

**This patient's legionella infection was: (check one)**

- Sporadic Case       Outbreak related       Unknown

## PUBLIC HEALTH ISSUES

## PUBLIC HEALTH ACTIONS

Y N NA	Y N NA
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Possible travel associated case	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Disease/transmission education provided
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Possible or definite hospital associated case	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Notified DIDE of travel history
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knows persons experiencing similar symptoms	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coordinated investigation with healthcare facility
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case is part of an outbreak OB # : _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient is lost to follow-up
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____