Legionellosis

COUNTY

FOR STATE USE ONLY #

___/___/___ case report ☐ confirmed ☐ presumptive

___/___/___ interstate ☐ suspect

Date investigation initiated: ____/____/____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County Zip

Language spoken _____

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT *(check all that apply)*

☐ Lab ☐ Infection Control Practitioner

☐ Physician ☐ _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient? ☐

DEMOGRAPHICS

SEX

☐ female ☐ male

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

HISPANIC ☐ yes ☐ no ☐ unknown

RACE

☐ White ☐ American Indian

☐ Black ☐ Asian/Pacific Islander

☐ unknown ☐ refused to answer

☐ other _____

Worksites/school/day care center/N/A _____

_____

Occupations/grade/N/A _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic: ☐ yes ☐ no ☐ unk

if yes, ONSET on ____/____/____
m d y

Check all that apply:

fever	☐ yes	☐ no	☐ unk
max. temp. ___ ___ . ___ ☐ F ☐ C			
cough	☐ yes	☐ no	☐ unk
bloody sputum	☐ yes	☐ no	☐ unk
dyspnea	☐ yes	☐ no	☐ unk
chest pain	☐ yes	☐ no	☐ unk
myalgia	☐ yes	☐ no	☐ unk
headache	☐ yes	☐ no	☐ unk
malaise	☐ yes	☐ no	☐ unk
anorexia	☐ yes	☐ no	☐ unk
delirium	☐ yes	☐ no	☐ unk
diarrhea	☐ yes	☐ no	☐ unk

max. no. stools/24 hrs _____

other _____

Hospitalized: ☐ yes ☐ no ☐ unk name of hospital _____

date of admission ____/____/____ date of discharge ____/____/____

Transferred to/from another hospital: ☐ yes ☐ no ☐ unk

transfer hospital name _____

Outcome: ☐ survived ☐ died ☐ unk date of death ____/____/____

Treated at long-term care facility : ☐ yes ☐ no ☐ unk

name of facility _____

phone of facility _____

Comments:

LABORATORY DATA

Test	Pos	Neg	Not Done	Date of collection	Specimen type
Direct Ag	☐	☐	☐	____/____/____	_____
PCR	☐	☐	☐	____/____/____	_____
Culture	☐	☐	☐	____/____/____	_____
DF A	☐	☐	☐	____/____/____	_____
Serum antibody	☐	☐	☐	____/____/____	_____

Isolate submitted to PHL? ☐ yes ☐ no ☐ unk

PHL specimen # _____

If culture positive,

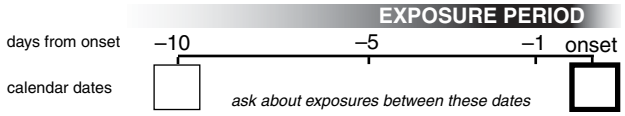
Species _____

Serotype _____

PATIENT'S NAME ▸

INFECTION TIMELINE

Enter onset date in box. Count back to figure probable exposure periods.



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? ☐ yes ☐ no ☐ unk Has the above case been reported? ☐ yes ☐ not yet

a close contact of a ***confirmed*** or ***presumptive*** case? ☐ yes ☐ no ☐ unk *if yes to any question, specify relevant names, dates, places, etc:*

Specify nature of contact: _____

Possible exposure:

Extrinsic risk factors

Manmade aquatic environment/equipment:

showers	a.	☐ yes	☐ no	☐ unk
spa/hot tub	b.	☐ yes	☐ no	☐ unk
air conditioner	c.	☐ yes	☐ no	☐ unk
room humidifier	d.	☐ yes	☐ no	☐ unk
evaporative condenser	e.	☐ yes	☐ no	☐ unk
ultrasonic mist machine	f.	☐ yes	☐ no	☐ unk
decorative fountain	g.	☐ yes	☐ no	☐ unk
other water-related	h.	☐ yes	☐ no	☐ unk

_____

Workplace ventilation	i.	☐ yes	☐ no	☐ unk
Recent residential plumbing repair	j.	☐ yes	☐ no	☐ unk

Recent travel

hotel	k.	☐ yes	☐ no	☐ unk
cruise ship	l.	☐ yes	☐ no	☐ unk
other travel-related	m.	☐ yes	☐ no	☐ unk

_____

Hospital-related:

mechanical ventilation	n.	☐ yes	☐ no	☐ unk
other respiratory therapy equipment	o.	☐ yes	☐ no	☐ unk
surgery	p.	☐ yes	☐ no	☐ unk
other hospital-related	q.	☐ yes	☐ no	☐ unk

_____

If hospital related, how long was patient hospitalized before onset?

☐ <2 days ☐ 2–9 days ☐ ≥10 days ☐ unk

Long-term-care facility (LTCF) related r. ☐ yes ☐ no ☐ unk

If LTCF related, how long was patient a resident before onset?

☐ <2 days ☐ 2–9 days ☐ ≥10 days ☐ unk

Facility name _____

phone_____

Work with potting soil	s.	☐ yes	☐ no	☐ unk
Other	t.	☐ yes	☐ no	☐ unk

_____

Intrinsic risk factors

age >60	u.	☐ yes	☐ no	☐ unk
cigarette smoking	v.	☐ yes	☐ no	☐ unk
alcohol consumption (3+drinks/day)	w.	☐ yes	☐ no	☐ unk
immunosuppressive therapy	x.	☐ yes	☐ no	☐ unk
corticosteroids	y.	☐ yes	☐ no	☐ unk
chronic lung disease	z.	☐ yes	☐ no	☐ unk
immunosuppressive conditions	1.	☐ yes	☐ no	☐ unk
swallowing disorder	2.	☐ yes	☐ no	☐ unk
transplantation	3.	☐ yes	☐ no	☐ unk
diabetes mellitus	4.	☐ yes	☐ no	☐ unk
hematologic malignancies	5.	☐ yes	☐ no	☐ unk
endstage renal disease	6.	☐ yes	☐ no	☐ unk
malignancies	7.	☐ yes	☐ no	☐ unk
cytotoxic chemotherapy	8.	☐ yes	☐ no	☐ unk

Comments

A

ADMINISTRATION

November 2003

Remember to copy patient's name to the top of this page.

Initial report sent to OHS on ____/____/____

Completed by _____ Date _____ Phone _____ Case investigation sent to OHS on ____/____/____