

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 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Not Hispanic/Latino	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](mailto: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.

State Health Dept. Case No.: \_\_\_\_\_

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
- 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:

<p><b>1 <input type="checkbox"/> CONFIRMED CASE</b></p> <p>1 <input type="checkbox"/> <b>Urine Antigen Positive:</b> <i>If yes,</i> Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p> <hr/> <p>2 <input type="checkbox"/> <b>Culture Positive:</b> <i>If yes,</i> Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p> <p>Site: 1 <input type="checkbox"/> lung biopsy 2 <input type="checkbox"/> respiratory secretions (e.g., sputum, BAL) 3 <input type="checkbox"/> pleural fluid 4 <input type="checkbox"/> blood 8 <input type="checkbox"/> other (specify) _____</p> <p>Species: _____ Serogroup: _____</p> <hr/> <p>3 <input type="checkbox"/> <b>Fourfold rise in antibody titer to <i>Legionella pneumophila</i> serogroup 1:</b> <i>If yes,</i> Initial (acute) titer: _____ Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p> <p>Convalescent titer: _____ Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p>	<p><b>2 <input type="checkbox"/> SUSPECT CASE</b></p> <p>4 <input type="checkbox"/> <b>Fourfold rise in antibody titer OTHER THAN <i>Legionella pneumophila</i> serogroup 1 or to multiple species or serogroups of <i>Legionella</i> using pooled antigen:</b> <i>If yes,</i> Initial (acute) titer: _____ Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p> <p>Convalescent titer: _____ Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p> <p>Species: _____ Serogroup: _____</p> <hr/> <p>5 <input type="checkbox"/> <b>Direct Fluorescent Antibody (DFA) or Immunohistochemistry (IHC) Positive:</b> <i>If yes,</i> Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p> <p>Site: 1 <input type="checkbox"/> lung biopsy 2 <input type="checkbox"/> respiratory secretions (e.g., sputum, BAL) 3 <input type="checkbox"/> pleural fluid 4 <input type="checkbox"/> blood 8 <input type="checkbox"/> other (specify) _____</p> <p>Species: _____ Serogroup: _____</p> <hr/> <p>6 <input type="checkbox"/> <b>Nucleic Acid Assay (e.g., PCR):</b> <i>If yes,</i> Date Collected: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Mo. Day Year</p> <p>Site: 1 <input type="checkbox"/> lung biopsy 2 <input type="checkbox"/> respiratory secretions (e.g., sputum, BAL) 3 <input type="checkbox"/> pleural fluid 4 <input type="checkbox"/> blood 8 <input type="checkbox"/> other (specify) _____</p> <p>Species: _____ Serogroup: _____</p>
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<p>Interviewer's Name:</p> <p>Affiliation:</p> <p>Telephone No.:</p>	<p>State Health Dept. Official who reviewed this report:</p> <p>Title:</p> <p>Telephone No.:</p>	<p><b>REPORTING INSTRUCTIONS</b></p> <p>Local Health Dept. Please submit this document to: <b>State/DHD/SSS via your CD clerk</b></p> <p>State Health Dept. Return completed form to: <b>Respiratory Diseases Branch, Mailstop C25 Office of Infectious Diseases Centers for Disease Control and Prevention 1600 Clifton Rd. NE, Atlanta, GA 30333</b></p>
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