LEGIONELLOSIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 49817 (R1/4-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3

Please complete all items on form.
Date format: MM/DD/YY

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ Employer ○ School ○ Day Care

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever . *(degrees)*
- ○ Myalgia
- ○ Cough
- ○ Pneumonia (X-ray Diagnosed)
- ○ Headache
- ○ Loss of Appetite
- ○ Diarrhea
- ○ Cramps
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Method of Testing Used:
- ○ Culture
  - Site:
- ○ DFA Stain
  - Site:
- ○ Serology **(must have both titers)**
  - Acute
  - Convalescent
- ○ Urine Antigen
- ○ Other, specify:

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code**

Physician/Hospital Phone

Was the patient hospitalized?
○ Yes ○ No

If Yes, admission date: / /

Discharge date: / /

Hospital:

Was the patient treated with antibiotics?
○ Yes ○ No ○ Unknown

If Yes, antibiotic

Date started / /

Was the patient immunocompromised?
○ Yes ○ No ○ Unknown

If Yes, why

Was infection associated with an outbreak?
○ Yes ○ No ○ Unknown

If Yes: ○ Convention ○ Hospital ○ Work ○ Other:

If Other, specify

Outcome?
○ Case survived ○ Death due to Legionellosis ○ Death unrelated ○ Unknown

Section 3. Risk Factors

During the two weeks prior to onset of symptoms, did the patient:

Visit a hospital as an outpatient/inpatient?
○ Yes ○ No ○ Unknown

If Yes, date: / /

Hospital name:

Work in a hospital?
○ Yes ○ No ○ Unknown

If Yes, date: / /

Hospital name:

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Section 3. Risk Factors (continued)

During the two weeks prior to onset of symptoms, did the patient:

Travel outside of Indiana?

○ Yes ○ No ○ Unknown

If Yes, where

Date of departure **Date of return**

Stay in a hotel/motel overnight?

○ Yes ○ No ○ Unknown

If Yes, place

Date

Smoke?

○ Yes ○ No **If Yes, how long (years):** **Packs/Items per day:**

Use a whirlpool/spa at home, in a health club, or elsewhere?

○ Yes ○ No ○ Unknown

If Yes, where

Date

Have exposure to any industrial cooling towers, showers, or air conditioners?

○ Yes ○ No ○ Unknown

If Yes, where

Date:

Do any gardening or work with potting soil?

○ Yes ○ No ○ Unknown

If Yes, where

Date

Use or have contact with a humidifier?

○ Yes ○ No ○ Unknown

If Yes, where

Date

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Section 3. Risk Factors (continued)

During the two weeks prior to onset of symptoms, did the patient:

Have contact with a decorative fountain?

○ Yes ○ No ○ Unknown

If Yes, where

Date

Attend a convention?

○ Yes ○ No ○ Unknown

If Yes, where

Date

Have an excavation or construction site within eyesight of home?

○ Yes ○ No ○ Unknown

If Yes, where

Date

Section 4. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number **Date**