

Patient Name: _____
LAST FIRST

DOB: ____/____/____
MM DD YYYY

Address: _____
STREET

CITY STATE ZIP CODE

Hospital: _____

Telephone Number: _____

Patient Chart No.: _____



Legionellosis Case Report Form

1. Please fill out this form as completely as possible.
2. Enter information into NBS.
3. Upload CRF to the [Foodborne and Waterborne Case Report Form Tracking REDCap database](#).
4. For possible/presumptive travel-associated or healthcare-associated cases, email legionella.health@tn.gov to notify TDH of an uploaded CRF.
5. TDH will review and submit to CDC after removing patient identifiers.

INVESTIGATION

Investigation ID (State Case No.): CAS1 _____ TN01

Interviewer: _____

Date of Report to Public Health: ____/____/____

Interview Date: ____/____/____

DEMOGRAPHICS

County of Residence: _____ **State:** _____ **Age:** _____

Days Months Years

Sex: Male Female

Race: American Indian / Alaskan Asian Black / African American

Ethnicity: Hispanic Not Hispanic Hawaiian / Pacific Islander White Unknown

Unknown Other: _____

CLINICAL INFORMATION / MEDICAL HISTORY

Date of symptom onset: ____/____/____

Diagnosis: Legionnaires' Disease (pneumonia, clinical or X-ray diagnosed)

Pontiac Fever (fever and myalgia without pneumonia)

Extra-pulmonary Infection (e.g. endocarditis, wound infection)

Did the patient die from this illness?

Yes No Unknown

Was the patient hospitalized for this illness? Yes No Unknown

If yes, Hospital Name: _____ **Admission Date:** ____/____/____

City: _____ **State:** _____ **Discharge Date:** ____/____/____

Is the patient a current or former smoker? Yes No Unknown

POSSIBLE SOURCES OF EXPOSURE

Occupation

Employer: _____ **Address:** _____

STREET

CITY STATE ZIP CODE

In the 14 days before onset, did the patient work in any of the following occupations?

Water device/system maintenance (e.g. cooling towers, plumbing, whirlpool spas)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Water-related leisure (e.g. hotels, cruise ships, water parks)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Industrial manufacturing plant with a water spray cooling system or process involving spraying water	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Commercial or long haul truck driver	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Commercial kitchen	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Custodial services (e.g. housekeeping, janitor)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Construction (esp. with spraying water, demolition or refurbishing)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Waste water treatment plant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Another occupation involving water exposures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

POSSIBLE SOURCES OF EXPOSURE

Travel

In the 14 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?

- Yes No Unknown

If yes (or possibly), please provide information for each stay away from home:

Accommodation Name (or private residence): _____	Room Number: _____
Address: _____	Arrival: ____/____/____
City: _____ State: _____ ZIP Code: _____ Country: _____	Departure: ____/____/____

Accommodation Name (or private residence): _____	Room Number: _____
Address: _____	Arrival: ____/____/____
City: _____ State: _____ ZIP Code: _____ Country: _____	Departure: ____/____/____

Accommodation Name (or private residence): _____	Room Number: _____
Address: _____	Arrival: ____/____/____
City: _____ State: _____ ZIP Code: _____ Country: _____	Departure: ____/____/____

Accommodation Name (or private residence): _____	Room Number: _____
Address: _____	Arrival: ____/____/____
City: _____ State: _____ ZIP Code: _____ Country: _____	Departure: ____/____/____

In the 14 days before onset, did the patient take a cruise?

- Yes No Unknown

Water Exposure / Medical Equipment

In the 14 days before onset, did the patient spend time in or near a whirlpool spa (i.e. hot tub)?

- Yes No Unknown

If yes, Name/location: _____ Date(s): _____

In the 14 days before onset, did the patient use a nebulizer, CPAP, BiPAP or other respiratory therapy device?

- Yes No Unknown

If yes, does the device use a humidifier? Yes No Unknown

If yes, What type of water is used in the device? Sterile Distilled Bottled Tap Other Unknown

Healthcare Settings

In the 14 days before onset, did the patient visit or stay in a healthcare facility (e.g. hospital, long term care, clinic, doctor/dentist office, rehab or any other healthcare facility)?

- Yes No Unknown

If yes (or possibly), please provide information for each visit:

Facility Type	Exposure Type	Exposure Details
<input type="checkbox"/> Clinic	<input type="checkbox"/> Employee	Facility Name: _____ Is this facility a transplant center?
<input type="checkbox"/> Hospital	<input type="checkbox"/> Inpatient	City: _____ State: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Long term care	<input type="checkbox"/> Outpatient	Reason for Visit: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Visitor/Volunteer	Start Date: ____/____/____ End Date: ____/____/____
<input type="checkbox"/> Clinic	<input type="checkbox"/> Employee	Facility Name: _____ Is this facility a transplant center?
<input type="checkbox"/> Hospital	<input type="checkbox"/> Inpatient	City: _____ State: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Long term care	<input type="checkbox"/> Outpatient	Reason for Visit: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Visitor/Volunteer	Start Date: ____/____/____ End Date: ____/____/____
<input type="checkbox"/> Clinic	<input type="checkbox"/> Employee	Facility Name: _____ Is this facility a transplant center?
<input type="checkbox"/> Hospital	<input type="checkbox"/> Inpatient	City: _____ State: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Long term care	<input type="checkbox"/> Outpatient	Reason for Visit: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Visitor/Volunteer	Start Date: ____/____/____ End Date: ____/____/____

Was this case associated with a healthcare exposure?

- Possible**, patient visited/stayed in a healthcare facility for a portion of the 14 days before onset
- Presumptive*** (previously "Definite"), patient had ≥10 days of continuous stay in a healthcare facility before onset
- No**, patient did not enter a healthcare facility during the 14 days before onset
- Other** (specify): _____
- Unknown**

POSSIBLE SOURCES OF EXPOSURE

Healthcare Settings (continued)

In the 14 days before onset, did the patient visit or stay in an assisted living facility or senior living facility?

Yes No Unknown

If yes (or possibly), please provide information:

Facility Type	Exposure Type	Exposure Details
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Resident	Facility Name: _____
	<input type="checkbox"/> Employee	City: _____ State: _____ ZIP Code: _____
	<input type="checkbox"/> Visitor	Start Date: ____/____/____ End Date: ____/____/____
	<input type="checkbox"/> Volunteer	
<input type="checkbox"/> Senior Living (Includes retirement homes without skilled nursing or personal care)	<input type="checkbox"/> Resident	Facility Name: _____
	<input type="checkbox"/> Employee	City: _____ State: _____ ZIP Code: _____
	<input type="checkbox"/> Visitor	Start Date: ____/____/____ End Date: ____/____/____
	<input type="checkbox"/> Volunteer	

CLUSTER / OUTBREAK

Was this case associated with a known outbreak or possible cluster? Yes No Unknown

If yes, specify Facility: _____ City: _____ State: _____

LABORATORY INFORMATION

Check all testing methods used for diagnosis:

Confirmed Methods

Urine Antigen

Date Collected: ____/____/____

Fourfold rise in *Legionella pneumophila* serogroup 1 antibody titer

Initial (acute) titer: _____ Date Collected: ____/____/____

Convalescent titer: _____ Date Collected: ____/____/____

Culture

Date Collected: ____/____/____

Site: Lung biopsy Respiratory secretions (e.g. sputum, BAL)
 Pleural fluid Blood Other: _____

Species: _____ Serogroup: _____

Nucleic Acid Assay (PCR)

Date Collected: ____/____/____

Site: Lung biopsy Respiratory secretions (e.g. sputum, BAL)
 Pleural fluid Blood Other: _____

Species: _____ Serogroup: _____

Suspect Methods

Direct Fluorescent Antibody (DFA) or Immunohistochemistry (IHC)

Date Collected: ____/____/____

Site: Lung biopsy Respiratory secretions (e.g. sputum, BAL)
 Pleural fluid Blood Other: _____

Species: _____ Serogroup: _____

Fourfold rise in *Legionella* antibody titer (non-Lp1 or multiple species/serogroups)

Initial (acute) titer: _____ Date Collected: ____/____/____

Convalescent titer: _____ Date Collected: ____/____/____

Species: _____ Serogroup: _____

Case Status: Confirmed Suspect Probable (Epi-Linked only)

COMMENTS

*Note: For presumptive healthcare-associated cases and cluster/outbreak investigations, please complete an outbreak report or the appropriate Investigation Report Form.