Patient Name:		[			
	FIRST		MM DD YY	YY	
Address:					
			lospital:		
CITY	STATE	ZIP CODE			
Telephone Number:		F	Patient Chart No.:		
TN Department of Health	<ul> <li>Legionellosis Case Report Form</li> <li>Please fill out this form as completely as possible.</li> <li>Enter information into NBS.</li> <li>Upload CRF to the Foodborne and Waterborne Case Report Form Tracking REDCap database.</li> <li>For possible/presumptive travel-associated or healthcare-associated cases, email legionella.health@tn.gov to notify TDH of an uploaded CRF.</li> <li>TDH will review and submit to CDC after removing patient identifiers.</li> </ul>				
INVESTIGATION					
Investigation ID (State Case No.): CAS1	TN01	Interviewer:			
Date of Report to Public Health://		Interview Date:	_//		
DEMOGRAPHICS					
County of Residence:	State:	Age:	🗆 Days 🛛 Mon	oths	
Sex:		American Indian / Alaskan		ck / African American	
Ethnicity: Hispanic Not Hispanic		Hawaiian / Pacific Islander Other:	□ White □ Unk		
CLINICAL INFORMATION / MEDICAL HISTOR	Y				
Date of symptom onset: / /	Diagno	osis: 🛛 Legionnaires' Dis	sease (pneumonia, clin	nical or X-ray diagnosed)	
Did the patient die from this illness?	0	_ *	ever and myalgia witho	, ,	
□ Yes □ No □ Unknown		Extra-pulmonary	Infection (e.g. endoca	rditis, wound infection)	
Was the patient hospitalized for this illness? $\Box$ Ye		Unknown			
If yes, Hospital Name:			://		
City: State:		Discharge Date:	//		
Is the patient a current or former smoker?	s 🗆 No 🗆	Unknown			
POSSIBLE SOURCES OF EXPOSURE					
Occupation / Volunteer Work					
Disabled Retired Unemployed					
Occupation/Position:	Address:				
	STR	EET			
Place of Work/Volunteering:	CIT	Y	STATE	ZIP CODE	
In the 14 days before onset, did the patient work in	any of the followin	g occupations?			
Water device/system maintenance (e.g. cooling	•		☐ Yes	□ No □ Unknown	
Water-related leisure (e.g. hotels, cruise ships,	water parks)		🛛 Yes	□ No □ Unknown	
Industrial manufacturing plant with a water spr	ay cooling system	or process involving spra	ying water 📋 Yes	□ No □ Unknown	
Commercial or long haul truck driver			🗆 Yes	□ No □ Unknown	
If yes, was water used to refill their windshie	d wiper fluid?			□ No □ Unknown	
Commercial kitchen				No Unknown	
Custodial services (e.g. housekeeping, janitor)				No Unknown	
Construction (esp. with spraying water, demoli	tion or refurbishing	g)			
Waste water treatment plant				□ No □ Unknown	
Another occupation involving water exposures			🗆 Yes	□ No □ Unknown	

Travel								
In the 14 days before onset, did the patient spend any <u>nights away from home (</u> 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	):							
Address:		Arrival://						
City: State:	ZIP Code: Country:	Departure:///						
· ·	mmodation Name (or private residence):							
Address:	ZIP Code: Country:	Arrival:// Departure://						
	):							
	ZIP Code: Country:	Departure://						
In the 14 days before onset, did the patient take	a cruise?							
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)?								
	Date(s):							
In the 14 days before onset, did the patient use a	a nebulizer, CPAP, BiPAP or other respiratory thera	apy device?						
If yes, does the device use a humidifier?								
If yes, What type of water is used in the		□ Tap □ Other □ Unknown						
• • •		☐ Tap ☐ Other ☐ Unknown						
Healthcare Settings In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?								
Healthcare Settings In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?  Yes No Unknown	e device? Sterile Distilled Bottled [ or stay in a healthcare facility (e.g. hospital, long to							
Healthcare Settings In the 14 days before onset, did the patient visit rehab or any other healthcare facility)? Yes No Unknown If yes (or possibly), please provide information	e device? Sterile Distilled Bottled [ or stay in a healthcare facility (e.g. hospital, long to on for each visit:							
Healthcare Settings In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?  Yes No Unknown	e device? Sterile Distilled Bottled or stay in a healthcare facility (e.g. hospital, long to on for each visit:	erm care, clinic, doctor/dentist office,						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No         Yes       No         Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee	e device? Sterile Distilled Bottled or stay in a healthcare facility (e.g. hospital, long to for each visit: Exposure Details	erm care, clinic, doctor/dentist office, Is this facility a transplant center?						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Pes       No       Unknown         If yes (or possibly), please provide information       Facility Type       Exposure Type         Clinic       Employee       Hospital       Inpatient	e device? Sterile Distilled Bottled Constay in a healthcare facility (e.g. hospital, long to be constay in a healthcare facility (e.g. hospital, long to be constant). State:	erm care, clinic, doctor/dentist office, Is this facility a transplant center? Yes No Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Pes       No       Unknown         If yes (or possibly), please provide information       Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient	e device? Sterile Distilled Bottled Constay in a healthcare facility (e.g. hospital, long to be for each visit: Exposure Details Facility Name: City: State: Reason for Visit:	erm care, clinic, doctor/dentist office, Is this facility a transplant center?						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Pes       No       Unknown         If yes (or possibly), please provide information       Facility Type       Exposure Type         Clinic       Employee       Hospital       Inpatient	e device? Sterile Distilled Bottled Source? Sterile Distilled Bottled Source facility (e.g. hospital, long to confor each visit:  Exposure Details Facility Name:State: City:State:State:	erm care, clinic, doctor/dentist office, Is this facility a transplant center? Yes □ No □ End Date://						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Pes       No       Unknown         If yes (or possibly), please provide information         Facility Type         Exposure Type         Clinic       Employee         Hospital       Inpatient         Other:       Visitor/Volunteer         Clinic       Employee	e device? Sterile Distilled Bottled Constay in a healthcare facility (e.g. hospital, long to the for each visit:  Exposure Details Facility Name:State: Reason for Visit:State: Start Date:/ Facility Name:	erm care, clinic, doctor/dentist office, Is this facility a transplant center? Yes □ No □ Unknown Is this facility a transplant center? Is this facility a transplant center?						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Other:       Visitor/Volunteer         Hospital       Inpatient	e device? Sterile Distilled Bottled Constay in a healthcare facility (e.g. hospital, long to constay in a he	erm care, clinic, doctor/dentist office,          Is this facility a transplant center?         Yes       No         Unknown         End Date:       //						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient	e device? Sterile Distilled Bottled Constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility (e.g. hospital, long to constay in a healthcare facility Name:	erm care, clinic, doctor/dentist office,          Is this facility a transplant center?         Yes       No         Unknown         End Date:       /         Is this facility a transplant center?         Yes       No         Unknown         End Date:       /         Yes       No         Unknown         Yes       No         Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Other:       Visitor/Volunteer         Hospital       Inpatient	a device? Sterile Distilled Bottled I   or stay in a healthcare facility (e.g. hospital, long to be compared by the second sec	Is this facility a transplant center?   Yes   No   Unknown   End Date:   Yes   No   Unknown   End Date:   Yes   No   Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Other:       Employee	a device? Sterile Distilled Bottled I   or stay in a healthcare facility (e.g. hospital, long to on for each visit:   Exposure Details   Facility Name:   City:	erm care, clinic, doctor/dentist office,          Is this facility a transplant center?         Yes       No         Unknown         End Date:       /         Yes       No         Is this facility a transplant center?         Yes       No         Is this facility a transplant center?         Yes       No         Is this facility a transplant center?         Is this facility a transplant center?         Is this facility a transplant center?						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Other:       Visitor/Volunteer         Other:       Employee         Hospital       Inpatient         Hospital       Inpatient	a device? Sterile Distilled Bottled I   or stay in a healthcare facility (e.g. hospital, long to be compared by the second sec	erm care, clinic, doctor/dentist office,          Is this facility a transplant center?         Yes       No         Unknown         End Date:       /         Yes       No         Is this facility a transplant center?         Yes       No         Is this facility a transplant center?         Yes       No         Is this facility a transplant center?         Is this facility a transplant center?         Is this facility a transplant center?						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Other:       Outpatient         Other:       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Long term care       Outpatient         Long term care       Outpatient	a device? Sterile Distilled Bottled I   or stay in a healthcare facility (e.g. hospital, long to   on for each visit:   Exposure Details   Facility Name:   City: State:   Start Date:   /   Facility Name:   City:   State:   Reason for Visit:   State:   State:   State:   State:   City:   State:   State:	Is this facility a transplant center?   Yes   Yes   Is this facility a transplant center?   Yes   Is this facility a transplant center?   Yes   No   Unknown   End Date:   Yes   No   Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Outpatient         Imployee       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Unpatient         Long term care       Outpatient         Long term care       Outpatient         Long term care       Outpatient         Impatient       Impatient         Long term care       Outpatient         Other:       Visitor/Volunteer	a device? Sterile Distilled Bottled I   or stay in a healthcare facility (e.g. hospital, long to   on for each visit:   Exposure Details   Facility Name:   City: State:   Start Date:   /   City:   Start Date:   /   Facility Name:   City:   Start Date:   /   Facility Name:   City:   Start Date:   /   Facility Name:   City:   Start Date:   /   Start Date:   /   State:	erm care, clinic, doctor/dentist office,          Is this facility a transplant center?         Yes       No         Unknown         End Date:       /         Yes       No         Unknown         End Date:       /         Yes       No         Unknown         End Date:       /         Is this facility a transplant center?         Is this facility a transplant center?         Is this facility a transplant center?         Yes       No         Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Long term care       Outpatient         Long term care       Outpatient         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Clinic       Employee         Hospital	a device? Sterile Distilled Bottled I   or stay in a healthcare facility (e.g. hospital, long to   on for each visit:   Exposure Details   Facility Name:   City: State:   Start Date:   /   Facility Name:   City:   Start Date:   /   Facility Name:   City:   Start Date:   /   Facility Name:   City:   Start Date:   /   Start Date:   Start Date:	Is this facility a transplant center?   Yes   Yes   Is this facility a transplant center?   Yes   Is this facility a transplant center?   Yes   No   Unknown   End Date:   Yes   No   Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Was this case associated with a healthcare export       Possible, patient visited/stayed in a healthcare	a device? Sterile Distilled Bottled I   or stay in a healthcare facility (e.g. hospital, long to the second or second	Is this facility a transplant center?   Yes   Yes   Is this facility a transplant center?   Yes   Is this facility a transplant center?   Yes   No   Unknown   End Date:   Yes   No   Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Was this case associated with a healthcare export       Possible, patient visited/stayed in a healthcare	a device? ☐ Sterile ☐ Distilled ☐ Bottled [ or stay in a healthcare facility (e.g. hospital, long to on for each visit: Exposure Details Facility Name: City:State: Reason for Visit: Start Date:/_/ Facility Name: City:State: Reason for Visit: Start Date:/_/ Facility Name: City:State: Reason for Visit: Start Date:/_/ Facility Name: City:State: City:State: City:State: Start Date:/_/ Facility Name: City:State: City:	Is this facility a transplant center?   Yes   Yes   Is this facility a transplant center?   Yes   Is this facility a transplant center?   Yes   No   Unknown   End Date:   Yes   No   Unknown						
Healthcare Settings         In the 14 days before onset, did the patient visit rehab or any other healthcare facility)?         Yes       No       Unknown         If yes (or possibly), please provide information         Facility Type       Exposure Type         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Clinic       Employee         Hospital       Inpatient         Long term care       Outpatient         Other:       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Hospital       Inpatient         Long term care       Outpatient         Other:       Visitor/Volunteer         Was this case associated with a healthcare export       Presumptive* (previously "Definite"), patient	a device? Sterile Distilled Bottled [ or stay in a healthcare facility (e.g. hospital, long to on for each visit: Exposure Details Facility Name: City:State: Reason for Visit: Start Date:/ Facility Name: City:State: Start Date:/ Facility Name: City:State: City:State: Reason for Visit: Start Date:/ Facility Name: City:State:	Is this facility a transplant center?   Yes   Yes   Is this facility a transplant center?   Yes   Is this facility a transplant center?   Yes   No   Unknown   End Date:   Yes   No   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 INO Unknown If yes (or possibly), please provide information:							
	Facility Type	Exposure Type	Exposure Details				
	Assisted Living		Facility Name:				
			City:		_State:	ZIP Code:	
		☐ Visitor ☐ Volunteer	Start Date://		End Date:	//	
	Senior Living	Resident	Facility Name:				
	(Includes retirement homes without skilled	Employee	City:			_ZIP Code:	
	nursing or personal care)	☐ Visitor ☐ Volunteer	Start Date://_		End Date://		
CLU	STER / OUTBREAK						
Was	this case associate	ed with a known out	reak or possible cluster?*	🗆 Yes 🗆 No	o 🛛 Unknown		
ľ	f yes, specify Facili	ty:		City:		State:	
LAE	ORATORY INFO	RMATION					
Che	ck all testing metho	ds used for diagnos	is:				
			Confirmed	Methods			
	] Urine Antigen			☐ Fourfold rise i	n Legionella pre	eumophila serogroup 1	
Date Collected:/ /		antibody titer					
				Initial (acute) titer: Date Collected:/			
				Convalescent tite	er: Da	ate Collected://	
			□ Nucleic Acid A	Assav (PCR)			
Date Collected:/		Date Collected: / /					
Site: Lung biopsy Respiratory secretions (e.g. sputum, BAL)		Site: Lung biopsy Respiratory secretions (e.g. sputum, BAL)					
			od 🛛 Other:		Pleural fluid Blood Other:		
	Species:	Serogroup:_			Se	erogroup:	
Suspect Methods							
		nt Antibody (DFA) or		Fourfold rise i			
Immunohistochemistry (IHC) Date Collected: / /		(non-Lp1 or multiple species/serogroups) Initial (acute) titer: Date Collected://					
			etions (e.g. sputum, BAL)			ate Collected://	
			ther:				
Species:        Serogroup:							
Case Status: Confirmed Suspect Probable (Epi-Linked only)							
COMMENTS							
*Note	: For presumptive healt	hcare-associated cases a	and cluster/outbreak investigations	, please complete an o	utbreak report or the	e appropriate Investigation Report Form.	