

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**

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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.