Patient's Name *(Last, First, MI):* _____ Phone: _____ Hospital: _____

Address *(Number, Street, Apt No., City, State, ZIP):* _____

Patient Chart No.: _____ ***PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC***

Form Approved
OMB No. 0920-0728

CDC Use Only
Case No.: _____

National Center for Immunization and Respiratory Diseases

LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY *LEGIONELLA* SPECIES)

U.S. Department of Health and and Human Services
Centers for Disease Control and Prevention (CDC), Atlanta, Georgia 30329
https://www.cdc.gov/legionella/index.html

1. State health dept. case no.:	2. Reporting state:	3. City of residence:	4. County of residence:	5. State of residence:

6. Industry:	7. Occupation:	8a. Date of birth *(mm/dd/yyyy):*	8b. Age:	9. Sex:
			◯ Days ◯ Months ◯ Years	◯ Male ◯ Female ◯ Unknown

10. Ethnicity:
- ◯ Hispanic/Latino
- ◯ Not Hispanic/Latino
- ◯ Unknown

11. Race *(check all that apply):*
- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Unknown

12. Diagnosis:
- ◯ Legionnaires' disease *(pneumonia, clinical or X-ray diagnosed)*
- ◯ Pontiac fever *(fever and myalgia without pneumonia)*
- ◯ Extrapulmonary legionellosis *(specify location):* _____

13. Date of symptom onset of legionellosis *(mm/dd/yyyy):* _____

14. Date of first report to public health at any level *(mm/dd/yyyy):* _____

15. Was the patient hospitalized during treatment for legionellosis?
- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, date of admission *(mm/dd/yyyy):* _____
Hospital name: _____
City, state: _____

16. Outcome of illness:
- ◯ Survived
- ◯ Died
- ◯ Still ill
- ◯ Unknown

17. In the 14 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?
◯ Yes ◯ No ◯ Unknown

If yes, please complete the following information:

Name of accomodation 1: _____
Street address: _____ Room number: _____
City: _____ State: _____ ZIP: _____
Country: _____ Date of arrival: _____ Date of departure: _____
Comments about travel:
_____

Name of accommodation 2: _____
Street address: _____ Room number: _____
City: _____ State: _____ ZIP: _____
Country: _____ Date of arrival: _____ Date of departure: _____
Comments about travel:
_____

***To add additional accommodations, see page 7.**

18. In the 14 days before onset, did the patient visit or stay in a healthcare setting (e.g., hospital, long-term care/rehab/skilled nursing facility, clinic)?
◯ Yes ◯ No ◯ Unknown

If yes, please complete the following information:

Name of healthcare facility 1: _____

Type of healthcare setting/facility:
- ○ Hospital
- ○ Long-term care
- ○ Clinic
- ○ Unknown
- ○ Other, specify: _____

Type of exposure:
- ○ Inpatient
- ○ Outpatient
- ○ Visitor or volunteer
- ○ Employee
- ○ Unknown
- ○ Other, specify: _____

Is this facility also a transplant center?
- ○ Yes
- ○ No
- ○ Unknown

Street address: _____ City: _____

State: _____ ZIP: _____ Reason for visit: _____

Date of arrival: _____ Date of departure: _____

Did the healthcare facility have in place a water management program to reduce the risk of *Legionella* growth and spread? ○ Yes ○ No ○ Unknown

Comments about healthcare facility:

_____

Name of healthcare facility 2: _____

Type of healthcare setting/facility:
- ○ Hospital
- ○ Long-term care
- ○ Clinic
- ○ Unknown
- ○ Other, specify: _____

Type of exposure:
- ○ Inpatient
- ○ Outpatient
- ○ Visitor or volunteer
- ○ Employee
- ○ Unknown
- ○ Other, specify: _____

Is this facility also a transplant center?
- ○ Yes
- ○ No
- ○ Unknown

Street address: _____ City: _____

State: _____ ZIP: _____ Reason for visit: _____

Date of arrival: _____ Date of departure: _____

Did the healthcare facility have in place a water management program to reduce the risk of *Legionella* growth and spread? ○ Yes ○ No ○ Unknown

Comments about healthcare facility:

_____

***To add additional healthcare facilities, see page 7.**

19. Was this case associated with a healthcare exposure?
- ○ **Presumptive:** Patient had 10 or more days of continuous stay at a healthcare facility during the 14 days before onset of symptoms
- ○ **Possible:** Patient had exposure to a healthcare facility for a portion of the entire 14 days prior to onset
- ○ **No:** No exposure to a healthcare facility in the 14 days prior to onset
- ○ Unknown

20. In the 14 days before onset, did the patient visit or stay in an assisted living facility or senior living facility? Assisted/senior living facilities do not provide skilled nursing or medical care.
- ○ Yes ○ No ○ Unknown

If yes, please complete the following information:

Type of setting/facility: ○ Assisted living facility ○ Senior living facility ○ Unknown

Name of assisted/senior living facility 1: _____

Type of exposure: ○ Resident ○ Visitor or volunteer ○ Employee ○ Other, specify: _____ ○ Unknown

Street address: _____

City: _____ State: _____ ZIP: _____

Date of arrival: _____ Date of departure: _____

Did the assisted/senior living facility have in place a water management program to reduce the risk of *Legionella* growth and spread?
- ○ Yes ○ No ○ Unknown

Comments about assisted or senior living facility:

_____

21. Was this case associated with an assisted or senior living facility?
- ○ **Presumptive:** Patient had 10 or more days of continuous stay at an assisted/senior living facility during the 14 days before onset of symptoms
- ○ **Possible:** Patient had exposure to an assisted/senior living facility for a portion of the entire 14 days prior to onset
- ○ **No:** No exposure to an assisted/senior living facility in the 14 days prior to onset
- ○ Unknown

22. Was this case associated with a known outbreak or possible cluster?
- ○ Yes ○ No ○ Unknown

If yes, specify name of facility, city, and state of outbreak:

Name of facility:

_____

City: _____ State: _____

23. If this case was associated with an outbreak reported to NORS (National Outbreak Reporting System), what is the CDC-assigned NORS outbreak ID?

_____

24. Laboratory diagnostic tests:

Tests	Date collected *(mm/dd/yyyy)*	Specimen type	Results
Urinary antigen test (UAT)	_____	Urine	◯ Positive ◯ Indeterminant ◯ Negative ◯ Not performed ◯ Unknown
Culture	_____	◯ Lower respiratory secretions (e.g., sputum, BAL) ◯ Other, specify: _____	◯ Positive ◯ Indeterminant ◯ Negative ◯ Not performed ◯ Unknown
Nucleic acid assay (e.g., PCR)	_____	◯ Lower respiratory secretions (e.g., sputum, BAL) ◯ Other, specify: _____	◯ Positive ◯ Indeterminant ◯ Negative ◯ Not performed ◯ Unknown
Direct fluorescent antibody (DFA) or immunohistochemistry (IHC)	_____	◯ Lower respiratory secretions (e.g., sputum, BAL) ◯ Other, specify: _____	◯ Positive ◯ Indeterminant ◯ Negative ◯ Not performed ◯ Unknown

25. If culture, nucleic acid assay (e.g., PCR), or DFA/IHC were performed, specify species and/or serogroup identified:

Species: _____ Serogroup: _____

26. Serologic tests:

Antibody titer test	Date collected *(mm/dd/yyyy)*	Quantitative titer value	Results
Antibody titer to *Legionella pneumophila* serogroup 1	Acute: _____ Convalescent: _____	Acute: _____ Convalescent: _____	◯ Positive (4x or greater rise in titer) ◯ Indeterminant ◯ Negative ◯ Not performed ◯ Unknown
Antibody titer OTHER THAN *Legionella pneumophila* serogroup 1 or to multiple species or serogroups of *Legionella* using pooled antigen	Acute: _____ Convalescent: _____	Acute: _____ Convalescent: _____	◯ Positive (4x or greater rise in titer) ◯ Indeterminant ◯ Negative ◯ Not performed ◯ Unknown

27. Was a specimen(s) sent to CDC for testing?

◯ Yes
◯ No
◯ Unknown

Date specimen(s) sent to CDC for testing: _____

28. Case status:

◯ Confirmed
◯ Suspect
◯ Probable
◯ Not a case

If probable, indicate epidemiologic link: _____

29. In the 14 days before onset, was the patient exposed to any of the following? *If yes,* indicate location and dates.

Potential exposure(s)	Yes/No/Unknown	Location (facility name, city, state)	Date(s)
Shower away from home	○ Yes ○ No ○ Unknown		
In or near a Hot tub	○ Yes ○ No ○ Unknown		
Near a decorative water fountain or water feature	○ Yes ○ No ○ Unknown		
Near a mister	○ Yes ○ No ○ Unknown		
Near a sprinkler	○ Yes ○ No ○ Unknown		
Recreational water park	○ Yes ○ No ○ Unknown		
Near some other water aerosolizing device: _____	○ Yes ○ No ○ Unknown		
Attend a convention, reception, conference, or other public gathering	○ Yes ○ No ○ Unknown		
Visit or live in a congregate living facility (e.g., correctional facilities, shelters, dormitories, etc.)	○ Yes ○ No ○ Unknown		
Visit an area with large buildings (e.g., shopping centers, high-rise complexes, etc.) that may have a cooling tower(s)	○ Yes ○ No ○ Unknown		
Construction/remodeling near home or place visited	○ Yes ○ No ○ Unknown		
Work with water device/system maintenance (e.g., cooling towers, plumbing, hot tub)	○ Yes ○ No ○ Unknown		
Work in water-related leisure (e.g., hotels, cruise ships, water parks)	○ Yes ○ No ○ Unknown		
Industrial/manufacturing plant with a water spray cooling system or processes involving spraying water	○ Yes ○ No ○ Unknown		
Commercial or long haul truck driving	○ Yes ○ No ○ Unknown		
Work in commercial kitchen	○ Yes ○ No ○ Unknown		
Work in custodial services (e.g., housekeeping, janitorial)	○ Yes ○ No ○ Unknown		
Work in construction (e.g., spraying water, demolition, refurbishing)	○ Yes ○ No ○ Unknown		
Work at wastewater treatment plant	○ Yes ○ No ○ Unknown		
Work in another occupation involving water exposures: _____	○ Yes ○ No ○ Unknown		

30. In the 14 days before onset, did the patient use respiratory therapy equipment (e.g., nebulizer, CPAP, BiPAP) for treatment of sleep apnea, COPD, asthma, or any other reason?

○ Yes ○ No ○ Unknown

**If yes* to respiratory therapy equipment, does this device use a humidifier?

○ Yes ○ No ○ Unknown

**If yes,* what type of water is used in the device? *(check all that apply)*

☐ Sterile ☐ Bottled ☐ Other
☐ Distilled ☐ Tap ☐ Unknown

31. In the 14 days before onset, did the patient take a cruise? ◯ Yes ◯ No ◯ Unknown

If yes,

Name of cruise line: _____ Name of ship: _____

Cruise departure city: _____ Cruise departure state: _____

Cruise departure country: _____ Cruise departure date: _____

Cruise return city: _____ Cruise return state: _____

Cruise return country: _____ Cruise return date: _____ Cabin number: _____

Ports of call:

City	State	Country	Date

32. Did the patient have any underlying conditions or prior illnesses? ◯ Yes ◯ No ◯ Unknown

If yes, indicate whether the patient has each of the following underlying conditions

Condition	Patient History		
AIDS	◯ Yes	◯ No	◯ Unknown
Alcohol abuse (current/past)	◯ Yes	◯ No	◯ Unknown
Asthma	◯ Yes	◯ No	◯ Unknown
Blood cancer	◯ Yes	◯ No	◯ Unknown
Bone marrow transplant	◯ Yes	◯ No	◯ Unknown
Broken skin	◯ Yes	◯ No	◯ Unknown
Cancer	◯ Yes	◯ No	◯ Unknown
Cancer treatment	◯ Yes	◯ No	◯ Unknown
Cerebrospinal fluid leak	◯ Yes	◯ No	◯ Unknown
Cerebrovascular accident	◯ Yes	◯ No	◯ Unknown
Chronic respiratory disease	◯ Yes	◯ No	◯ Unknown
Chronic hepatitis C	◯ Yes	◯ No	◯ Unknown
Cirrhosis/liver failure	◯ Yes	◯ No	◯ Unknown
Cochlear prosthesis	◯ Yes	◯ No	◯ Unknown
Complement deficiency disease	◯ Yes	◯ No	◯ Unknown
Congestive heart failure	◯ Yes	◯ No	◯ Unknown
Connective tissue disorder	◯ Yes	◯ No	◯ Unknown
Coronary arteriosclerosis	◯ Yes	◯ No	◯ Unknown
Corticosteroids	◯ Yes	◯ No	◯ Unknown
Current chronic dialysis	◯ Yes	◯ No	◯ Unknown
Deafness/profound hearing loss	◯ Yes	◯ No	◯ Unknown
Dementia	◯ Yes	◯ No	◯ Unknown
Diabetes mellitus	◯ Yes	◯ No	◯ Unknown
Emphysema/COPD	◯ Yes	◯ No	◯ Unknown
HIV infection	◯ Yes	◯ No	◯ Unknown
Hodgkin's disease (clinical)	◯ Yes	◯ No	◯ Unknown
Immunoglobulin deficiency	◯ Yes	◯ No	◯ Unknown
Immunosuppressive therapy	◯ Yes	◯ No	◯ Unknown
Intravenous drug user	◯ Yes	◯ No	◯ Unknown

Condition	Patient History		
Kidney disease	◯ Yes	◯ No	◯ Unknown
Leukemia	◯ Yes	◯ No	◯ Unknown
Multiple myeloma	◯ Yes	◯ No	◯ Unknown
Multiple sclerosis	◯ Yes	◯ No	◯ Unknown
Myocardial infarction	◯ Yes	◯ No	◯ Unknown
Nephrotic syndrome	◯ Yes	◯ No	◯ Unknown
Neuromuscular disorder	◯ Yes	◯ No	◯ Unknown
Obesity	◯ Yes	◯ No	◯ Unknown
Paralysis	◯ Yes	◯ No	◯ Unknown
Parkinson's disease	◯ Yes	◯ No	◯ Unknown
Peptic ulcer	◯ Yes	◯ No	◯ Unknown
Peripheral neuropathy	◯ Yes	◯ No	◯ Unknown
Peripheral vascular disease	◯ Yes	◯ No	◯ Unknown
Premature birth	◯ Yes	◯ No	◯ Unknown
Renal failure/dialysis	◯ Yes	◯ No	◯ Unknown
Seizure disorder	◯ Yes	◯ No	◯ Unknown
Sickle cell trait	◯ Yes	◯ No	◯ Unknown
Smoker – current	◯ Yes	◯ No	◯ Unknown
Smoker – former	◯ Yes	◯ No	◯ Unknown
Solid organ malignancy	◯ Yes	◯ No	◯ Unknown
Solid organ transplant	◯ Yes	◯ No	◯ Unknown
Spleen missing	◯ Yes	◯ No	◯ Unknown
Splenectomy/asplenia	◯ Yes	◯ No	◯ Unknown
Systemic lupus erythematosus	◯ Yes	◯ No	◯ Unknown
Trouble swallowing (dysphagia)	◯ Yes	◯ No	◯ Unknown
Other (specify):	◯ Yes	◯ No	◯ Unknown
Unknown	◯ Yes	◯ No	

33. Was the patient or proxy interviewed by public health?

◯ Yes ◯ No ◯ Unknown

Comments:

Interviewer's name: _____

Affiliation: _____ Phone: _____

State health dept. official who reviewed this report: _____

Title: _____ Phone: _____

Local Health Dept. please submit this document to:

State/DHD/SSS via your communicable disease clerk

State Health Dept. return completed form to:

travellegionella@cdc.gov

Appendix (Additional Facilities)

(Additional accomodations – continued from page 1***)***

Name of accomodation 3: _____

Street address: _____ Room number: _____

City: _____ State: _____ ZIP: _____

Country: _____ Date of arrival: _____ Date of departure: _____

Comments about travel:

_____

Name of accomodation 4: _____

Street address: _____ Room number: _____

City: _____ State: _____ ZIP: _____

Country: _____ Date of arrival: _____ Date of departure: _____

Comments about travel:

_____

(Additional healthcare facilities – continued from page 2***)***

Name of healthcare facility 3: _____

Type of healthcare setting/facility:
- ◯ Hospital
- ◯ Long-term care
- ◯ Clinic
- ◯ Unknown
- ◯ Other, specify: _____

Type of exposure:
- ◯ Inpatient
- ◯ Outpatient
- ◯ Visitor or volunteer
- ◯ Employee
- ◯ Unknown
- ◯ Other, specify: _____

Is this facility also a transplant center?
- ◯ Yes
- ◯ No
- ◯ Unknown

Street address: _____ City: _____

State: _____ ZIP: _____ Reason for visit: _____

Date of arrival: _____ Date of departure: _____

Did the healthcare facility have in place a water management program to reduce the risk of *Legionella* growth and spread? ◯ Yes ◯ No ◯ Unknown

Comments about healthcare setting:

_____

(Additional assisted/senior living facilities – continued from page 2***)***

If yes, what type? ◯ Assisted living facility ◯ Senior living facility ◯ Unknown

Name of assisted/senior living facility 2: _____

Type of exposure: ◯ Resident ◯ Visitor or volunteer ◯ Employee ◯ Other, specify: _____ ◯ Unknown

Street address: _____

City: _____ State: _____ ZIP: _____

Date of arrival: _____ Date of departure: _____

Did the assisted/senior living facility have in place a water management program to reduce the risk of *Legionella* growth and spread? ◯ Yes ◯ No ◯ Unknown

Comments about assisted or senior living facility:

_____