

Legionellosis

PATIENT DEMOGRAPHICS

Name (last, first): _____
 Address (mailing): _____
 Address (physical): _____
 City/State/Zip: _____
 Phone (home): _____ Phone (work/cell) : _____
 Occupation _____
 Alternate contact: Parent/Guardian Spouse Other
 Name: _____ Phone: _____

Birth date: __/__/____ Age: _____
 Gender: Male Female Unk
 Ethnicity: Not Hispanic or Latino
 Hispanic or Latino Unk
 Race: White Black/Afr. Amer.
 (Mark all that apply) Native HI/Other PI
 Am. Ind/AK Native
 Asian Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
 Investigation Start Date: __/__/____
 Earliest date reported to LHD: __/__/____
 Earliest date reported to State: __/__/____

Entered in WVEDSS? Yes No Unk
 Case Classification:
 Confirmed Probable Suspect
 Not a case Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: Laboratory Hospital Private Provider Public Health Agency Other
 Reporter Name: _____ Reporter Phone : _____
 Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __/__/____ Diagnosis date: __/__/____ Recovery date: __/__/____

Clinical Findings	Hospitalization
<p>Clinical Findings Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legionnaires' Disease (Pneumonia, x-ray diagnosed) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pontiac Fever (Fever, myalgia without pneumonia) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Admitted to intensive care unit <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mechanical ventilation or intubation required</p> <p>Predisposing Factors <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Smokes tobacco <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Immunosuppressive therapy or disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic diabetes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Underlying illness, Specify: _____</p>	<p>Hospitalization Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalized for this illness Hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____</p> <p>Death Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Died due to this illness Date of death: __/__/____</p>

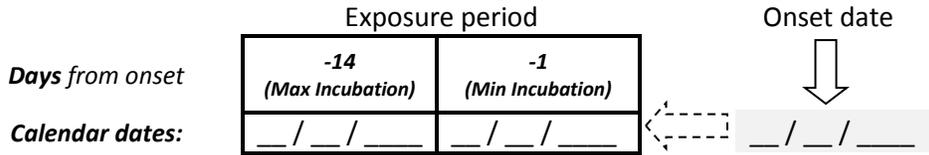
LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

Specimen source: _____ Collection date: __/__/____

Y N U
 Legionella culture (normally sterile site) Species _____
 L. pneumophilla serogroup 1 antigen detected in urine
 L. pneumophilla serogroup 1 serum antibody titer with >= 4 fold rise (acute and convalescent serum pair)
 Titer to Legionella species/serogroups other than L. pneumophilla serogroup 1, >= 4 fold rise
 Legionella antigen or organism detected by DFA, Immunohistochemistry, or other method in respiratory secretions
 Legionella species detected by validated nucleic acid assay

INFECTION TIMELINE

*Instructions:
Enter onset date in grey
box. Count backward to
determine probable
exposure period*



EPIDEMIOLOGIC EXPOSURES

In the two weeks before onset, did patient:

- | | |
|--|--|
| | Y N U |
| Get in or spend time near a whirlpool spa (i.e. hot tub)? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Travel or stay overnight somewhere other than usual residence? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

If yes, give cities, name of location and date/s where available.

City	Name of Lodging or Spa	Date(s) of Stay

- | | | |
|---|--|---------------------------|
| | Y N U | If yes, name of facility: |
| Have dental work? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Visit hospital as an outpatient? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Visit or stay in a healthcare setting? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Visit or stay in an assisted living facility or senior living facility? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Work in a hospital? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | _____ |
| Use a nebulizer, CPAP, BiPAP or other respiratory equipment? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| If yes, does this device use a humidifier? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |

Was case hospital related (nosocomial)?

- | | |
|--|---|
| <input type="checkbox"/> Not nosocomial: No inpatient or outpatient hospital visits in the 10 days prior to onset of symptoms | <input type="checkbox"/> Possibly nosocomial: Patient hospitalized 2-9 days before onset of legionella infection |
| <input type="checkbox"/> Definitely nosocomial: Patient hospitalized continuously for >= 10 days before onset of legionella infection | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Unknown | |

Was this patient's legionella infection: (check one)

- Associated with outbreak (Specify location): _____
- Sporadic Case
- Unknown

PUBLIC HEALTH ISSUES

- | |
|--|
| Y N NA |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Possible travel associated case |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Possible or definite hospital associated case |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knows persons experiencing similar symptoms |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case is part of an outbreak |

PUBLIC HEALTH ACTIONS

- | |
|---|
| Y N NA |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Disease/Transmission Education Provided |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Notified DIDE of travel history |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Coordinated investigation with healthcare facility |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Patient is lost to follow-up |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____ |

NOTES

