Patient's Name: _____ (Last, First, M.I.) _____ (Telephone No.) Hospital: _____

Address: _____ (Number, Street, Apt. No., City, State) _____ (Zip Code) Patient Chart No.: _____

*-- Patient identifier information is not transmitted to CDC --*

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)
Atlanta, Georgia 30333

# LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY LEGIONELLA SPECIES)

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved OMB No. 0920-0009

## – PATIENT INFORMATION –

1. State Health Dept. Case No. _____
2. Reporting State: ☐☐
3. (CDC Use Only) Case No. ☐☐☐☐☐
4. County of Residence _____
5. State of Residence ☐☐
6. Occupation: _____

7a. Date of Birth: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

7b. Age: ☐☐☐ 1☐ Days 2☐ Mos. 3☐ Years

8. Sex: 1☐ Male 2☐ Female

9. Race: 1☐ White 2☐ Black 3☐ American Indian/Alaskan Native 4☐ Asian/Pacific Islander 8☐ Other 9☐ Unk

10. Ethnic Origin: 1☐ Hispanic/Latino 2☐ Not Hispanic/Latino 9☐ Unk

11. Possible sources of exposure:

IN THE TWO WEEKS BEFORE ONSET, DID PATIENT:

a) Travel or stay overnight somewhere other than usual residence? 1☐ Yes 2☐ No 9☐ Unk

If Yes, give cities and lodging where available: CITY _____ LODGING _____

* *For suspected travel related cases, please contact CDC or pertinent state health departments immediately.*

b) Have dental work? 1☐ Yes 2☐ No 9☐ Unk If Yes, name of dental office: _____

c) Visit a hospital as an outpatient? 1☐ Yes 2☐ No 9☐ Unk If Yes, name of hospital: _____

d) Work in a hospital? 1☐ Yes 2☐ No 9☐ Unk If Yes, name of hospital: _____

12. Was case hospital related (nosocomial)?

2☐ Not nosocomial: No inpatient or outpatient hospital visits in the 10 days prior to onset of symptoms.

1☐ Definitely nosocomial: Patient hospitalized continuously for ≥ 10 days before onset of legionella infection.

3☐ Possibly nosocomial: Patient hospitalized 2 - 9 days before onset of legionella infection.

8☐ Other(Specify) _____

9☐ Unk

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

1☐ Associated with outbreak (Specify location): _____

2☐ Sporadic case 9☐ Unk

## – CLINICAL ILLNESS –

14. Diagnosis: (check one)

1☐ Legionnaires' Disease (Pneumonia, X-ray diagnosed)

2☐ Pontiac fever (fever, myalgia without pneumonia)

8☐ Other (Specify) _____

9☐ Unk

15. Date of symptom onset of Legionellosis: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

16. Was patient hospitalized for Legionellosis? 1☐ Yes 2☐ No 9☐ Unk

Hospital name: _____

Hospital address: _____

17. Outcome of illness: 1☐ Survived 2☐ Died 9☐ Unk

## – CASE DEFINITION –

*Confirmed case has a compatible clinical history and meets at least one of the following criteria:*

1) isolation of *Legionella* species from lung tissue, respiratory secretions, pleural fluid, blood or other sterile site
2) demonstration of *L. pneumophila*, serogroup 1, in lung tissue, respiratory secretions, or pleural fluid by direct fluorescent antibody testing
3) fourfold or greater rise in immunoflourescent antibody titer to *L. pneumophila*, serogroup 1, to 128 or greater
4) detection of *L. pneumophila* serogroup 1 antigen in urine

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to DHHS Reports Clearance Officer, Paperwork Reduction Project (0920-0009), Rm 531 H., H.H. Humphrey Bldg 200 Independence Ave., SW, Washington, DC 20201. While your response is voluntary your cooperation is necessary for the understanding and control of this disease.

## – METHOD OF DIAGNOSIS –

PLEASE CHECK ALL METHODS OF DIAGNOSIS WHICH APPLY

1 ☐ Culture Positive: If Yes,
Date: Mo. Day Year
Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions 3 ☐ pleural fluid 4 ☐ blood 8 ☐ Other: (Specify) _____
Species: _____ Serogroup: _____

2 ☐ DFA Positive: If Yes,
Date: Mo. Day Year
Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions 3 ☐ pleural fluid 4 ☐ blood 8 ☐ Other: (Specify) _____
Species: _____ Serogroup: _____

3 ☐ Fourfold rise in antibody titer: If Yes,
Date: Mo. Day Year
List Species and Serogroup in assay used:
Initial (acute) titer 1: _____ Species: _____ Serogroup: _____
Convalescent titer 1: _____ Species: _____ Serogroup: _____

4 ☐ Urine Antigen Positive: If Yes,
Date: Mo. Day Year

## – INTERVIEWER IDENTIFICATION –

Interviewer's Name: _____

Affiliation: _____

Telephone No.: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Date of Interview: Mo. Day Year

## – CDC USE ONLY –

*Return completed form to:*

Respiratory Diseases Branch, Mailstop C23
National Center for Infectious Diseases
Centers for Disease Control and Prevention
1600 Clifton Rd. NE
Atlanta, GA 30333

Check the appropriate answer: Serogroup: _____

1 ☐ *L. pneumophila*
2 ☐ *L. bozemanii*
3 ☐ *L. dumoffii*
4 ☐ *L. gormanii*
5 ☐ *L. micdadei*
6 ☐ *L. feeleii*
7 ☐ *L. longbeachae*
8 ☐ Mixed: (specify) _____
88 ☐ Other: (specify) _____
99 ☐ Unk

## – COMMENTS –