

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

Local ID Number _____

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

LEGIONELLOSIS CASE REPORT

Red boxes indicate required fields

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
<input type="checkbox"/> English	<input type="checkbox"/> Spanish				
<input type="checkbox"/> Other: _____	Ethnicity (check one)				
Social Security Number (9 digits)				DOB (mm/dd/yyyy)	Age
Address Number & Street - Residence				Apartment / Unit Number	
City / Town				State	Zip Code
Census Tract		County of Residence		Country of Residence	
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone / Pager		Work / School Telephone	
E-mail Address			Other Electronic Contact Information		
Work / School Location			Work / School Contact		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			If Yes, Est. Delivery Date (mm/dd/yyyy)		
Medical Record Number			Patient's Parent / Guardian Name		
Occupation Setting (see list on page 8)			Other (Describe / Specify)		
Occupation (see list on page 8)			Other (Describe / Specify)		
CLINICAL INFORMATION					
Physician Name - Last Name				First Name	
				Telephone Number	

- English
- Spanish
- Other: _____
- Ethnicity (check one)**
- Hispanic / Latino
- Non-Hispanic / Non-Latino
- Unk
- Race***
(check all that apply, race descriptions on page 8)
- African-American / Black
- American Indian or Alaska Native
- Asian (check all that apply)
 - Asian Indian Japanese
 - Cambodian Korean
 - Chinese Laotian
 - Filipino Thai
 - Hmong Vietnamese
 - Other: _____
- Pacific Islander (check all that apply)
 - Native Hawaiian Samoan
 - Guamanian
 - Other: _____
- White
- Other: _____
- Unk

*Comment: self-identity or self-reporting
 The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

Clear Page

First three letters of
patient's last name:

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SIGNS AND SYMPTOMS						
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)		Date First Sought Medical Care (mm/dd/yyyy)		
HOSPITALIZATION						
Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, how many total hospital nights?	
If there were any ER or hospital stays related to this illness, specify details below.						
HOSPITALIZATION - DETAILS						
Hospital Name 1		Street Address		Admit Date (mm/dd/yyyy)		
		City		Discharge / Transfer Date (mm/dd/yyyy)		
		State	Zip Code	Telephone Number	Medical Record Number	
		Discharge Diagnosis				
Hospital Name 2		Street Address		Admit Date (mm/dd/yyyy)		
		City		Discharge / Transfer Date (mm/dd/yyyy)		
		State	Zip Code	Telephone Number	Medical Record Number	
		Discharge Diagnosis				
TREATMENT / MANAGEMENT						
Received Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			If Yes, specify the treatment below.			
TREATMENT / MANAGEMENT - DETAILS						
Treatment Type 1 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		Treatment Name		Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)	
Treatment Type 2 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other		Treatment Name		Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)	
OUTCOME						
Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk		If Survived, Survived as of _____ (mm/dd/yyyy)			Date of Death (mm/dd/yyyy)	

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First three letters of patient's last name:

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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

<p><i>Specimen Type 1</i></p> <input type="checkbox"/> Urine <input type="checkbox"/> Respiratory <input type="checkbox"/> Blood <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Other: _____	<i>Collection Date (mm/dd/yyyy)</i>	
	<i>Type of Test</i> <input type="checkbox"/> Antigen <input type="checkbox"/> Culture <input type="checkbox"/> DFA <input type="checkbox"/> PCR <input type="checkbox"/> IHC <input type="checkbox"/> Immunofluorescence antibody <input type="checkbox"/> Other: _____	
	<i>Legionella Species</i> <input type="checkbox"/> <i>Legionella pneumophila</i> <input type="checkbox"/> Other: _____	<i>Serogroup</i>
	<i>Results</i>	
	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	
	<i>Laboratory Name</i>	<i>Telephone</i>

If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.

<p><i>Specimen Type 2</i></p> <input type="checkbox"/> Urine <input type="checkbox"/> Respiratory <input type="checkbox"/> Blood <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Other: _____	<i>Collection Date (mm/dd/yyyy)</i>	
	<i>Type of Test</i> <input type="checkbox"/> Antigen <input type="checkbox"/> Culture <input type="checkbox"/> DFA <input type="checkbox"/> PCR <input type="checkbox"/> IHC <input type="checkbox"/> Immunofluorescence antibody <input type="checkbox"/> Other: _____	
	<i>Legionella Species</i> <input type="checkbox"/> <i>Legionella pneumophila</i> <input type="checkbox"/> Other: _____	<i>Serogroup</i>
	<i>Results</i>	
	<i>Interpretation</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal	
	<i>Laboratory Name</i>	<i>Telephone</i>

If Serum (acute) is submitted, then Serum (convalescent) must also be submitted.

IMAGING SUMMARY

<i>Anatomic Site 1</i>	<i>Date (mm/dd/yyyy)</i>	<i>Type of Imaging</i> <input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other (specify): _____
	<i>Result</i>	
	<i>Interpretation</i>	
	<i>Hospital Name</i>	<i>Telephone</i>

<i>Anatomic Site 2</i>	<i>Date (mm/dd/yyyy)</i>	<i>Type of Imaging</i> <input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Other (specify): _____
	<i>Result</i>	
	<i>Interpretation</i>	
	<i>Hospital Name</i>	<i>Telephone</i>

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EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD IS 10 DAYS PRIOR TO ILLNESS ONSET

EXPOSURE / RISK FACTORS

DID THE PATIENT HAVE ANY OF THE FOLLOWING MEDICAL EXPOSURES DURING THE INCUBATION PERIOD?

Medical Exposure	Yes	No	Unk	If Yes, Specify as Noted		
Inpatient hospitalization				Name of Hospital		
				Address		
				From (mm/dd/yyyy)	To (mm/dd/yyyy)	Still hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Visit hospital as an outpatient				Mechanical ventilation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
				Other respiratory equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Visited hospitalized patient				Describe		
				Name of Hospital		
Employed by hospital				Location		
				Date (mm/dd/yyyy)		
Dental procedure				Name of Hospital		
				Location		
Dental procedure				Describe Procedure		
				Name of Dental Office		
Long term care facility (LTCF) or skilled nursing facility (SNF) resident				Address		
				Date (mm/dd/yyyy)		
Employed by LTCF or SNF				Name of Facility		
				Address		
Employed by LTCF or SNF				From (mm/dd/yyyy)	To (mm/dd/yyyy)	Still a resident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Name of Facility		Location

Other Medical or Healthcare Setting Exposures of Interest (describe)

Was this case associated with a healthcare exposure (hospital or long term care facility)?

Definitely: Patient was hospitalized or a resident of a long term care facility for the entire 10 days prior to onset

Possibly: Patient had exposures to a healthcare facility for a portion of the 10 days prior to onset

No: No exposure to a healthcare facility in the 10 days prior to onset

Other (specify): _____

Unknown

In the 10 days before onset, did the patient visit, stay, or work in an <u>assisted living facility</u> ?	Type of Exposure?		Name of Facility	
	<input type="checkbox"/> Resident <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Start of Stay (mm/dd/yyyy)	End of Stay (mm/dd/yyyy)	City	State
In the 10 days before onset, did the patient visit, stay, or work in a <u>senior living facility</u> (includes retirement homes <u>without</u> skilled nursing or personal care)?	Type of Exposure?		Name of Facility	
	<input type="checkbox"/> Resident <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Start of Stay (mm/dd/yyyy)	End of Stay (mm/dd/yyyy)	City	State

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First three letters of patient's last name:

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EXPOSURE / RISK FACTORS (continued)

WAS PATIENT EXPOSED TO ANY OF THE FOLLOWING ARTIFICIAL AQUATIC ENVIRONMENTS / EQUIPMENT DURING THE INCUBATION PERIOD?				
Aquatic Exposure	Yes	No	Unk	If Yes, Specify as Noted
Spa / hot tub / whirlpool				Location
Mister				Location
Decorative fountain				Location
Room humidifier				Location
Nebulizer, CPAP, BIPAP or any other respiratory therapy equipment				Does this device use a humidifier? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				If the device uses a humidifier, what type of water is used in the device? <input type="checkbox"/> Sterile <input type="checkbox"/> Distilled <input type="checkbox"/> Bottled <input type="checkbox"/> Tap <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
Other water-related exposure (e.g., handheld shower, ice machine)				Location
Other Exposures (specify)				

DID THE PATIENT PARTICIPATE IN ANY OF THE FOLLOWING EVENTS OR ACTIVITIES DURING THE INCUBATION PERIOD?

Exposure	Yes	No	Unk	If Yes, Specify as Noted
Conference or convention				Location
Other activities of interest				Describe

TRAVEL HISTORY

Did patient travel outside county of residence during the 10 days preceding illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.
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TRAVEL HISTORY - DETAILS

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

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ACCOMMODATION HISTORY

<p><i>In the 10 days before illness onset, did the patient spend any nights away from home (excluding healthcare settings)?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p><i>If Yes, specify details of all accommodations below.</i></p>
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ACCOMMODATION HISTORY - DETAILS

<p><i>Accommodation Name 1</i> <i>(e.g., name of hotel, friend's house)</i></p>	<p><i>Address</i></p>	<p><i>City</i></p>	<p><i>State</i></p>	<p><i>Zip</i></p>
	<p><i>Country</i></p>	<p><i>Room Number</i></p>	<p><i>Arrival Date (mm/dd/yyyy)</i></p>	<p><i>Departure Date (mm/dd/yyyy)</i></p>
<p><i>Accommodation Name 2</i> <i>(e.g., name of hotel, friend's house)</i></p>	<p><i>Address</i></p>	<p><i>City</i></p>	<p><i>State</i></p>	<p><i>Zip</i></p>
	<p><i>Country</i></p>	<p><i>Room Number</i></p>	<p><i>Arrival Date (mm/dd/yyyy)</i></p>	<p><i>Departure Date (mm/dd/yyyy)</i></p>

CONTACTS / OTHER ILL PERSONS

<p><i>Any contacts with similar illness?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>	<p><i>If Yes, specify details below.</i></p>
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ILL CONTACTS - DETAILS

<p><i>Name 1</i></p>	<p><i>Age</i></p>	<p><i>Gender</i></p>	<p><i>Telephone Number</i></p>	<p><i>Type of Contact / Relationship</i></p>	<p><i>Illness Onset Date (mm/dd/yyyy)</i></p>	
	<p><i>Street Address</i></p>			<p><i>Exposure Dates Shared with Index Case (mm/dd/yyyy)</i></p>		
	<p><i>City</i></p>	<p><i>State</i></p>	<p><i>Zip Code</i></p>	<p><i>Date First Reported to Public Health (mm/dd/yyyy)</i></p>		
<p><i>Name 2</i></p>	<p><i>Age</i></p>	<p><i>Gender</i></p>	<p><i>Telephone Number</i></p>	<p><i>Type of Contact / Relationship</i></p>	<p><i>Illness Onset Date (mm/dd/yyyy)</i></p>	
	<p><i>Street Address</i></p>			<p><i>Exposure Dates Shared with Index Case (mm/dd/yyyy)</i></p>		
	<p><i>City</i></p>	<p><i>State</i></p>	<p><i>Zip Code</i></p>	<p><i>Date First Reported to Public Health (mm/dd/yyyy)</i></p>		

NOTES / REMARKS

REPORTING AGENCY

<p><i>Investigator Name</i></p>	<p><i>Local Health Jurisdiction</i></p>	<p><i>Telephone Number</i></p>	<p><i>Date (mm/dd/yyyy)</i></p>
<p><i>First Reported By</i></p> <p><input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____</p>			

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EPIDEMIOLOGICAL LINKAGE			
<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>		
DISEASE CASE CLASSIFICATION			
<i>Case Classification (see case definition below)</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected			
<i>Disease Classification</i> <input type="checkbox"/> Legionnaires' Disease (illness with pneumonia) <input type="checkbox"/> Pontiac fever (illness without pneumonia)			
OUTBREAK			
<i>Part of known outbreak?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, extent of outbreak</i> <input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
<i>Mode of Transmission</i> <input type="checkbox"/> Point source <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____	<i>Vehicle of Outbreak</i>	<i>Pattern 1 ID Number</i>	<i>Pattern 2 ID Number</i>
STATE USE ONLY			
<i>State Case Classification</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information	<i>Was this case reported to CDC at travellegionella@cdc.gov?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
<i>If case was healthcare-associated, was CDPH HAI Program notified?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>CDPH HAI Program Case Classification</i> <input type="checkbox"/> Healthcare-associated <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not healthcare-associated		
CASE DEFINITION			
<u>LEGIONELLOSIS (2010)</u>			
CLINICAL DESCRIPTION Legionellosis is associated with two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac fever, a milder illness without pneumonia.			
LABORATORY CRITERIA FOR DIAGNOSIS			
- Suspected:			
<ul style="list-style-type: none"> • By seroconversion: fourfold or greater rise in antibody titer to specific species or serogroups of <i>Legionella</i> other than <i>L. pneumophila</i> serogroup 1 (e.g., <i>L. micdadei</i>, <i>L. pneumophila</i> serogroup 6). • By seroconversion: fourfold or greater rise in antibody titer to multiple species of <i>Legionella</i> using pooled antigen and validated reagents. • By the detection of specific <i>Legionella</i> antigen or staining of the organism in respiratory secretions, lung tissue, or pleural fluid by direct fluorescent antibody (DFA) staining, immunohistochemistry (IHC), or other similar method, using validated reagents. • By detection of <i>Legionella</i> species by a validated nucleic acid assay. 			
- Confirmed:			
<ul style="list-style-type: none"> • By culture: isolation of any <i>Legionella</i> organism from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluid. • By detection of <i>Legionella pneumophila</i> serogroup 1 antigen in urine using validated reagents. • By seroconversion: Fourfold or greater rise in specific serum antibody titer to <i>Legionella pneumophila</i> serogroup 1 using validated reagents. 			
CASE CLASSIFICATION			
- Suspected:			
<ul style="list-style-type: none"> • A clinically compatible case that meets at least one of the presumptive (suspect) laboratory criteria. • Travel-associated: a case that has a history of spending at least one night away from home, either in the same country of residence or abroad, in the ten days before onset of illness. 			
- Confirmed:			
<ul style="list-style-type: none"> • A clinically compatible case that meets at least one of the confirmatory laboratory criteria. • Travel-associated: a case that has a history of spending at least one night away from home, either in the same country of residence or abroad, in the ten days before onset of illness. 			

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RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
OCCUPATION SETTING	
<ul style="list-style-type: none"> • Childcare / Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other 	<ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other
OCCUPATION	
<ul style="list-style-type: none"> • Adult film actor / actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory / seasonal worker • Agriculture - other / unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other / unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other / unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker 	<ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other / unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent / guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other / unknown • Teacher / employee - preschool or kindergarten • Teacher / employee - elementary or middle school • Teacher / employee - high school • Teacher / instructor / employee - college or university • Teacher / instructor / employee - other / unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other / unknown • Volunteer • Other • Refused • Unknown