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 --

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

LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY LEGIONELLA SPECIES)

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. Ethnicity: 1☐ Hispanic/Latino 9☐ Unk 2☐ Not Hispanic/Latino

10. Race: 1☐ American Indian/Alaskan Native 2☐ Asian 3☐ Black or African American 4☐ Native Hawaiian or Other Pacific Islander 5☐ White 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.

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

9☐ Unk

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

8☐ Other(Specify) ______

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)

8☐ Other (Specify) ______

2☐ Pontiac fever (fever, myalgia without pneumonia)

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 9☐ Unk 2☐ Died

– 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 CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address. 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 ☐☐☐☐

Local Health Dept. Please submit this document to:

State/DHD/SSS via your CD reporting clerk

State Health Dept. 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

– CDC USE ONLY –

Check the appropriate answer: Serogroup: ____________

1 ☐ *L. pneumophila* 6 ☐ *L. feeleii*

2 ☐ *L. bozemanii* 7 ☐ *L. longbeachae*

3 ☐ *L. dumoffii* 8 ☐ Mixed: (specify)____________

4 ☐ *L. gormanii* 88 ☐ Other: (specify)____________

5 ☐ *L. micdadei* 99 ☐ Unk

– COMMENTS –