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)

CDC SAFER·HEALTHIER·PEOPLE™

Form Approved OMB No. 0920-0009

– PATIENT INFORMATION –

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

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

– 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 –

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

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 –