

Patient's Name: _____ (Last, First, MI) Phone No.: () _____
 Address: _____ (Number, Street, Apt No.) Patient Chart No.: _____
 _____ (City, State) _____ (Zip Code) Hospital: _____

- Patient identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR DISEASE CONTROL AND PREVENTION
 ATLANTA, GA 30333

2012 LEGIONELLOSIS ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK



Form Approved
 OMB No. 0920-XXXX (for CDC)
 Exp. Date xx/xx/20xx

- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE (Residence of Patient) [][]	2. COUNTY (Residence of Patient) _____	3. STATE I.D.: [][][][][][]	4a. HOSPITAL/LAB I.D. WHERE FIRST CULTURE IDENTIFIED OR FIRST POSITIVE TEST [][][][][]	4b. HOSPITAL I.D. WHERE PATIENT TREATED: [][][][][]	
5. STATE HEALTH DEPT. CASE NO. (From CDC Legionellosis case report form for passive surveillance): [][][][][][][][]	6. DATE OF SYMPTOM ONSET OF LEGIONELLOSIS: (note this is NOT date of admission) Mo. Day Year [][][][][][][]	7a. WAS PATIENT HOSPITALIZED? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If YES, date of admission: Mo. Day Year [][][][][][][] Date of discharge: Mo. Day Year [][][][][][][]			
7b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	7c. Did the patient require mechanical ventilation? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	8a. Excluding the current hospitalization, was the patient hospitalized at any time in the 10 days prior to illness onset? If yes, Date of admission: Mo. Day Year [][][][][][][] Date of discharge: Mo. Day Year [][][][][][][]		8b. If YES, hospital I.D.: [][][][][]	
9a. Where was the patient a resident in the 10 days prior to illness onset? (Check all that apply) 1 <input type="checkbox"/> Private residence 1 <input type="checkbox"/> Long term care facility 1 <input type="checkbox"/> Long term acute care facility 1 <input type="checkbox"/> Homeless 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Assisted Living 1 <input type="checkbox"/> Acute care hospital 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Unknown			9b. If resident of a facility, what was the name of the facility? _____	10a. Was patient transferred from another hospital? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	10b. If YES, hospital I.D.: [][][][][]
11. DATE OF BIRTH: Mo. Day Year [][][][][][][]	12a. AGE (at time of onset) [][][] 12b. Is age in day/mo/yr? 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.	13. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	14a. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	14b. RACE (Check all that apply) 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Unknown	
15a. WEIGHT: _____ lbs _____ oz OR _____ kg OR <input type="checkbox"/> Unknowns 15b. HEIGHT: _____ ft _____ in OR _____ cm OR <input type="checkbox"/> Unknown 15c. BMI: _____ OR <input type="checkbox"/> Unknown	16. TYPE OF INSURANCE (Check all that apply) 1 <input type="checkbox"/> Private 1 <input type="checkbox"/> Medicare 1 <input type="checkbox"/> Medicaid/state assistance program 1 <input type="checkbox"/> Military 1 <input type="checkbox"/> Indian Health Service (IHS) 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Uninsured 1 <input type="checkbox"/> Unknown				
17. OUTCOME 1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown			18. If patient died, was the initial culture or first positive test obtained from autopsy? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		
19. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF ADMISSION? 1 <input type="checkbox"/> CT 2 <input type="checkbox"/> X-ray 3 <input type="checkbox"/> Both 4 <input type="checkbox"/> Neither 9 <input type="checkbox"/> Unknown If yes, check all that apply from the radiology report: 1 <input type="checkbox"/> Pneumonia/bronchopneumonia 1 <input type="checkbox"/> Consolidation 1 <input type="checkbox"/> Lobar (NOT interstitial) infiltrate For pneumonia/consolidation/infiltrate: 1 <input type="checkbox"/> Single lobar 1 <input type="checkbox"/> Multiple lobar infiltrate (unilateral) 1 <input type="checkbox"/> Multiple lobar infiltrate (bilateral) 1 <input type="checkbox"/> Air space/alveolar density/opacity/disease 1 <input type="checkbox"/> Atelectasis 1 <input type="checkbox"/> Cavitation 1 <input type="checkbox"/> Pleural effusion 1 <input type="checkbox"/> Pneumonitis 1 <input type="checkbox"/> Pulmonary edema 1 <input type="checkbox"/> Interstitial infiltrate 1 <input type="checkbox"/> Empyema 1 <input type="checkbox"/> ARDS (acute respiratory distress syndrome) 1 <input type="checkbox"/> Cannot rule out pneumonia 1 <input type="checkbox"/> No evidence of pneumonia 1 <input type="checkbox"/> Report not available 1 <input type="checkbox"/> Other (specify) _____			20. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA?: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No* 9 <input type="checkbox"/> Unknown* *If no or unknown, choose syndrome or infection type: 1 <input type="checkbox"/> Pontiac fever (fever and myalgia without pneumonia) 8 <input type="checkbox"/> Extrapulmonary infections (specify): _____ 9 <input type="checkbox"/> Unknown		
21. Did this patient have a positive flu test 10 days prior to or following a positive Legionella or positive Legionella culture? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	22. Discharge diagnosis (check all that apply): 1 <input type="checkbox"/> 482.84 (Legionnaires' disease) 1 <input type="checkbox"/> 482 (other bacterial pneumonia) 1 <input type="checkbox"/> 482.8 (pneumonia due to other specified bacteria) 1 <input type="checkbox"/> 482.83 (other gram-negative bacteria) 1 <input type="checkbox"/> 482.89 (pneumonia due to other specified bacteria) 1 <input type="checkbox"/> 482.9 (bacterial pneumonia unspecified) 1 <input type="checkbox"/> 483 (pneumonia due to other specified organism) 1 <input type="checkbox"/> 483.8 (pneumonia due to other specified organism) 1 <input type="checkbox"/> 484 (pneumonia in infectious diseases classified elsewhere) 1 <input type="checkbox"/> 484.8 (pneumonia in infectious diseases classified elsewhere) 1 <input type="checkbox"/> 485 (bronchopneumonia organism unspecified) 1 <input type="checkbox"/> 486 (pneumonia, organism unspecified) 1 <input type="checkbox"/> None of these listed 1 <input type="checkbox"/> No KD-9 codes in chart 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, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-XXXX). Do not send the completed form to this address.				

23. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1 None 1 Unknown

- | | | | |
|---|---|--|---|
| 1 <input type="checkbox"/> AIDS or CD4 count <200 | 1 <input type="checkbox"/> Diabetes Mellitus | 1 <input type="checkbox"/> Leukemia | 1 <input type="checkbox"/> Renal Failure/Dialysis |
| 1 <input type="checkbox"/> Alcohol Abuse | 1 <input type="checkbox"/> Dysphagia | 1 <input type="checkbox"/> Multiple Myeloma | 1 <input type="checkbox"/> Seizure/Seizure Disorder |
| 1 <input type="checkbox"/> Asthma | 1 <input type="checkbox"/> Emphysema/COPD | 1 <input type="checkbox"/> Multiple Sclerosis | 1 <input type="checkbox"/> Sickle Cell Anemia |
| 1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD | 1 <input type="checkbox"/> Former Smoker | 1 <input type="checkbox"/> Nephrotic Syndrome | 1 <input type="checkbox"/> Solid Organ Malignancy |
| 1 <input type="checkbox"/> Bone Marrow Transplant (BMT) | 1 <input type="checkbox"/> Heart Failure/CHF | 1 <input type="checkbox"/> Neuromuscular Disorder | 1 <input type="checkbox"/> Solid Organ Transplant |
| 1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke | 1 <input type="checkbox"/> HIV Infection | 1 <input type="checkbox"/> Obesity | 1 <input type="checkbox"/> Splenectomy/Asplenia |
| 1 <input type="checkbox"/> Chronic Renal Insufficiency | 1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma | 1 <input type="checkbox"/> Parkinson's Disease | 1 <input type="checkbox"/> Systemic Lupus Erythematosus (SLE) |
| 1 <input type="checkbox"/> Cirrhosis/Liver Failure | 1 <input type="checkbox"/> Immunoglobulin Deficiency | 1 <input type="checkbox"/> Peripheral Neuropathy | 1 <input type="checkbox"/> Other (specify) _____ |
| 1 <input type="checkbox"/> Complement Deficiency | 1 <input type="checkbox"/> Immunosuppressive Therapy
(Steroids, Chemotherapy, Radiation) | 1 <input type="checkbox"/> Plegias/Paralysis | |
| 1 <input type="checkbox"/> Current Smoker | 1 <input type="checkbox"/> IVDU | 1 <input type="checkbox"/> Premature Birth (specify gestational age
at birth) <input type="text"/> <input type="text"/> (wks) | |

Legionella Test	Was this test ordered?	Date Collected	Site	Result	Species
24. Urine Antigen, EIA	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	___/___/___		1 <input type="checkbox"/> Positive 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	
25. Culture	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	___/___/___	1 <input type="checkbox"/> Sputum 2 <input type="checkbox"/> BAL/bronchial washing 3 <input type="checkbox"/> Lung tissue 4 <input type="checkbox"/> Pleural fluid 5 <input type="checkbox"/> Blood 8 <input type="checkbox"/> Other (specify) _____	1 <input type="checkbox"/> Positive 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	1 <input type="checkbox"/> <i>L. pneumophila</i> If yes, list serogroup: 1 <input type="checkbox"/> serogroup 1 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> <i>L. species (non-pneumophila)</i> 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown or not specified
26. Paired Serology, IFA or ELISA	Acute 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Acute ___/___/___		Acute 1 <input type="checkbox"/> Positive If yes, titer: _____ 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	Acute Species: _____ Serogroup(s): _____
	Convalescent 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	Convalescent ___/___/___		Convalescent 1 <input type="checkbox"/> Positive If yes, titer: _____ 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	Convalescent Species: _____ Serogroup(s): _____
27. PCR (direct specimen only)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	___/___/___	1 <input type="checkbox"/> Sputum 2 <input type="checkbox"/> BAL/bronchial washing 3 <input type="checkbox"/> Lung tissue 4 <input type="checkbox"/> Pleural fluid 5 <input type="checkbox"/> Blood 8 <input type="checkbox"/> Other (specify) _____	1 <input type="checkbox"/> Positive 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	1 <input type="checkbox"/> <i>L. pneumophila</i> 2 <input type="checkbox"/> <i>L. species (non-pneumophila)</i> 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown or not specified
28. DFA (direct fluorescence assay, direct specimen only)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	___/___/___	1 <input type="checkbox"/> Sputum 2 <input type="checkbox"/> BAL/bronchial washing 3 <input type="checkbox"/> Lung tissue 4 <input type="checkbox"/> Pleural fluid 5 <input type="checkbox"/> Blood 8 <input type="checkbox"/> Other (specify) _____	1 <input type="checkbox"/> Positive 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	1 <input type="checkbox"/> <i>L. pneumophila</i> If yes, list serogroup: 1 <input type="checkbox"/> serogroup 1 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> <i>L. species (non-pneumophila)</i> 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown or not specified
29. IHC (immunohistochemistry)	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	___/___/___	1 <input type="checkbox"/> Sputum 2 <input type="checkbox"/> BAL/bronchial washing 3 <input type="checkbox"/> Lung tissue 4 <input type="checkbox"/> Pleural fluid 5 <input type="checkbox"/> Blood 8 <input type="checkbox"/> Other (specify) _____	1 <input type="checkbox"/> Positive 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	1 <input type="checkbox"/> <i>L. pneumophila</i> If yes, list serogroup: 1 <input type="checkbox"/> serogroup 1 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> <i>L. species (non-pneumophila)</i> 8 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown or not specified

30. COMMENTS: _____

- SURVEILLANCE OFFICE USE ONLY -

31. Was case first identified through audit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	32. Was this case also identified through routine passive notifiable disease surveillance? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	33. CRF Status: 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Incomplete 3 <input type="checkbox"/> Edited & Correct 4 <input type="checkbox"/> Chart unavailable after 3 requests	34. Does this case have recurrent disease? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown If yes, previous (1st) state ID: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	35. Case status: 1 <input type="checkbox"/> Confirmed 2 <input type="checkbox"/> Suspect	36. Date reported to EIP site: Mo. Day <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year <input type="text"/> <input type="text"/>	37. Initials of S.O.: _____
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Submitted By: _____ Phone No. : () _____ Date: ___/___/___
Physician's Name: _____ Phone No. : () _____