

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

- Patient identifier information is not transmitted to CDC -

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

2013 LEGIONELLOSIS ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK



- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE: 2. COUNTY: 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.: 6. DATE OF SYMPTOM ONSET OF LEGIONELLOSIS: 7a. WAS PATIENT HOSPITALIZED?: 7b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?: 7c. Did the patient require mechanical ventilation?: 8a. Excluding the current hospitalization, was the patient hospitalized at any time in the 10 days prior to illness onset?: 8b. If YES, hospital I.D.: 9a. Where was the patient a resident in the 10 days prior to illness onset?: 9b. If resident of a facility, what was the name of the facility?: 9c. Was patient transferred from another hospital?: 10b. If YES, hospital I.D.: 11. DATE OF BIRTH: 12a. AGE: 12b. Is age in day/mo/yr?: 13. SEX: 14a. ETHNIC ORIGIN: 14b. RACE: 15a. WEIGHT: 15b. HEIGHT: 15c. BMI: 16. TYPE OF INSURANCE: 17. OUTCOME: 18. If patient died, was the initial culture or first positive test obtained from autopsy?: 19. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF ADMISSION?: 20. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA?: 21. Did this patient have a positive flu test 10 days prior to or following a positive Legionella test or positive Legionella culture?: 22. Discharge diagnosis (check all that apply):

- IMPORTANT - PLEASE COMPLETE THE BACK OF THIS FORM -

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

Legionella Test	Was this test ordered?	Date Collected	Site	Result	Species
<b>24. Urine Antigen, EIA</b>	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	
<b>25. Culture</b>	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"/> <i>L. species, other (specify)</i> _____ 9 <input type="checkbox"/> <i>L. species, unknown or not specified</i>
<b>26. Paired Serology, IFA or ELISA</b>	<b>Acute</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>Acute</b> ___/___/___		<b>Acute</b> 1 <input type="checkbox"/> Positive If yes, titer: _____ 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	<b>Acute</b> Species: _____ Serogroup(s): _____
	<b>Convalescent</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>Convalescent</b> ___/___/___		<b>Convalescent</b> 1 <input type="checkbox"/> Positive If yes, titer: _____ 2 <input type="checkbox"/> Negative 9 <input type="checkbox"/> Unknown or Indeterminate	<b>Convalescent</b> Species: _____ Serogroup(s): _____
<b>27. PCR (direct specimen only)</b>	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"/> <i>L. species, other (specify)</i> _____ 9 <input type="checkbox"/> <i>L. species, unknown or not specified</i>
<b>28. DFA (direct fluorescence assay, direct specimen only)</b>	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"/> <i>L. species, other (specify)</i> _____ 9 <input type="checkbox"/> <i>L. species, unknown or not specified</i>
<b>29. IHC (immunohistochemistry)</b>	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"/> <i>L. species, other (specify)</i> _____ 9 <input type="checkbox"/> <i>L. species, unknown or not specified</i>

**30. COMMENTS:** \_\_\_\_\_

**- SURVEILLANCE OFFICE USE ONLY -**

<b>31. Was case first identified through audit?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>32. Was this case also identified through routine passive notifiable disease surveillance?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>33. CRF Status:</b> 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	<b>34. Does this case have recurrent disease?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>If yes, previous (1st) state ID:</b> <input type="text"/>	<b>35. Case status:</b> 1 <input type="checkbox"/> Confirmed 2 <input type="checkbox"/> Suspect	<b>36. Date reported to EIP site:</b> Mo. <input type="text"/> Day <input type="text"/> Year <input type="text"/>	<b>37. Initials of S.O.:</b> _____
---	--	--	---	---	---	---------------------------------------

Submitted By: \_\_\_\_\_ Phone No. : ( \_\_\_\_\_ ) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
Physician's Name: \_\_\_\_\_ Phone No. : ( \_\_\_\_\_ ) \_\_\_\_\_