Case ID# _____

Form Approved
OMB No. 0920-1011
Exp. Date 03/31/2017

SECTION I. SCREENING FOR SUSPECT LD CASES

MRN:_____

Encounter (FIN): _____

Gender: _____

DOB: _____ Age: _____ Race/Ethnicity: _____

Type of Residence: ◻ Home ◻ LTCF ◻ Other _____

Todays date: __ / __ / __

Date of admission: __ / __ / __

Abstractors initials: _____

Did any of the following develop ≥48 hours of admission (do not count if present on admission)?

1. Pneumonia symptoms? (Cough, shortness of breath)
◻ Yes ◻ No (if yes, then continue to Section II)

2. Abnormal CXR / CT suggestive of pneumonia/infiltrate?
◻ Yes ◻ No (if yes, then continue to section II)

3. Was another etiology identified (other than Legionella)?
◻ Yes ◻ No (if yes, then stop)

Chart Abstraction Form – Legionnaires' Disease

Case ID# _____

SECTION II. TYPE OF CASE
Information Source (check all that apply):
□ hospital chart
□ other (if other specify) _____

1. **Type of exposures to Hospital A during incubation period *(check all that apply)*:**
   □ Inpatient □ Outpatient □ Visitor □Volunteer □Employee

2. **Case definition:**
   □ Confirmed Case □ Suspected Case □ Possible Case □ Subclinical case

3. **Case Classification:**
   □ Definitely outbreak-associated □ Possibly outbreak-associated
   □ Non-outbreak associated

If non-outbreak-associated, END HERE. Otherwise, continue to next page.

SECTION III. LEGIONELLA-SPECIFIC TESTING

1. **Respiratory specimen collected and processed specifically for *Legionella* culture?**
   _____ Yes _____ No _____ Unknown

   a.) **If YES,**
   Specimen type: (e.g., expectorated sputum, BAL, etc.) _____
   Collected Date: ____/____/ ____ Laboratory Name:_____
   Results:_____

   b.) **If NO,**
   Respiratory specimen collected for any culture?
   _____ Yes _____ No _____ Unknown
   If Yes,
   Specimen type: (e.g., expectorated sputum, BAL, etc.) _____
   Collected Date: ____/____/ ____ Laboratory: _____
   Results:_____

2. **Urine specimen collected for *Legionella* urine antigen testing?**
   _____ Yes _____ No _____ Unknown
   Collected Date: ____/____/ ____ Laboratory Name: _____
   Results: _____

3. **Other *Legionella* testing? _____**

SECTION IV. MEDICAL HISTORY

□ COPD/Emphysema/Chronic Lung Disease

□ Diabetes

□ Congestive Heart Failure

□ History of stroke/CVA

□ Chronic Renal Insuffiency (CRI/CKD) or End-Stage Renal Disease (ESRD)

□ Cirrhosis / Liver Disease

□ Cancer (Type: _____; Date of diagnosis __/__/__)

□ Organ Transplant (Type:_____) Date of transplant: __ / __ / __

□ Bone Marrow Transplant; Date of transplant: __ / __ / __

□ HIV/AIDS, CD4 count: _____ Date: __ / __ / __

□ Dementia

□ Taking systemic steroid

□ History of chemotherapy Date: __ / __ / __ (Is this 1st cycle of induction chemo? □ Yes □ No)

□ History of radiation Date: __ / __ / __

□ History of pneumonia in prior year, Date: __ / __ / __

□ Other (_____)

□ Other (_____)

History of smoking: □ Yes □ No □ Unknown
If yes: □ Current □ Former □ Unknown

History of alcohol abuse: □ Yes □ No □ Unknown

History of other substance abuse: □ Yes □ No □ Unknown
Specify substance(s): _____

SECTION V. SIGNS AND SYMPTOMS

□ Shortness of breath; Date of onset: __ / __ / __

□ Cough; Date of onset: __ / __ / __

□ Fever >100.5°F; Date of onset: __ / __ / __

□ Diarrhea (3 stools/24h); Date of onset: __ / __ / __

□ Nausea or Vomiting; Date of onset: __ / __ / __

□ Confusion (altered mental status); Date of onset: __ / __ / __

□ Other (_____);Date of onset: __ / __ / __

□ Other (_____);Date of onset: __ / __ / __

BEST SYMPTOM ONSET DATE: __ / __ / __

(If the patient did not have prior respiratory symptoms, choose, the onset date of cough or shortness of breath, whichever occurs first. Otherwise, use the earliest date when other symptoms suggestive of Legionella infection began.)

SECTION VI. RADIOGRAPHIC FINDINGS

Document any radiographic findings 14 days after onset of symptoms above. If multiple chest images are available, report the first for which evidence of pneumonia is noted.

□ Chest X-ray

If Yes, when and what were the findings?
Date: _____/_____ / _____
□ Normal □ Abnormal
Result:
□ New Infiltrate □ Old / Unchanged Infiltrate □ Indeterminate □ Consolidation
□ No infiltrate □ Not available / Unknown
Findings (impression): _____

□ CT Scan

If Yes, when and what were the findings?
Date: _____/_____ / _____
□ Normal □ Abnormal
Result:
□ New Infiltrate □ Old / Unchanged Infiltrate □ Indeterminate □ Consolidation
□ No infiltrate □ Not available / Unknown
Findings (impression): _____

SECTION VII. VITAL SIGNS

Highest O2 demand (FiO2): _____ Date (*earliest*):_____

Pulse ox (lowest recorded): _____ Date: _____
Tmax: _____ Date _____

SECTION VIII. LABORATORY VALUES

TEST	Result	Date
WBC (lowest)		____ / ____ / ____
% Neutrophils		____ / ____ / ____
% Lymphocytes		____ / ____ / ____
WBC (highest)		____ / ____ / ____
Hemoglobin (lowest)		____ / ____ / ____
Platelets (lowest)		____ / ____ / ____
Na (lowest)		____ / ____ / ____
Cr (highest)		____ / ____ / ____
Required dialysis	◻ Yes ◻ No	
AST (highest)		____ / ____ / ____
ALT (highest)		____ / ____ / ____
Total bilirubin (highest)		____ / ____ / ____
Ferritin (highest)		____ / ____ / ____
CRP (highest)		____ / ____ / ____
ESR (highest)		____ / ____ / ____

SECTION IX. INVASIVE PROCEDURES

Document procedures done 14 days prior to the onset of symptoms above

Procedure name	Date
◻ NG/OG tube placement	____ / ____ / ____
◻ ET/OT/Other Intubation	____ / ____ / ____
◻ Lumbar puncture	____ / ____ / ____
◻ Thoracentesis	____ / ____ / ____
◻ Paracentesis	____ / ____ / ____
◻ Bronchoscopy	____ / ____ / ____
◻ Central line placement	____ / ____ / ____
◻ Arterial line placement	____ / ____ / ____
◻ Other_____	____ / ____ / ____
◻ Other_____	____ / ____ / ____

SECTION X. ANTIBIOTICS / IMMUNOSUPPRESION REGIMENS					
Antibiotic / immunosuppressive therapy	**Dose**	**Route**	**Start Date**	**End Date**	**Check if continued as outpatient**
□ Levofloxacin (Levoquin)					
□ Moxifloxacin					
□ Ciprofloxacin (Cipro)					
□ Azithromycin (Zithromax)					
□ Erythromycin					
□ Rifampin					
□ Rifapentine					
□ Linezolid					
□ Tetracycline					
□ Doxycycline					
□ Quinupristin/ dalfopristin (Synercid)					
□ Chemotherapy regimen (specify): _____					
□ Radiation therapy (specify): _____					
□ Systemic steroids (specify): _____					
Other (specify): _____					
Other (specify): _____					
Other (specify): _____					
Other (specify): _____					

SECTION XI. CLINICAL OUTCOMES

□ ICU Stay

a.) If ICU stay,

a. Number of days in ICU: _____ (count days where any time was spent in ICU)

DISPOSITION:

□ Still Hospitalized
□ Transferred to another facility (list:_____)
□ Discharged Home
□ Unknown
□ Deceased

b.) If deceased,

a. Date of death: _____ (mm/dd/yyyy)
b. Was a post-mortem examination performed? ___Yes ___No ____Unknown
i. If yes, are tissue specimens available? ____ Yes ____No ____ Unknown

DISCHARGE DIAGNOSIS

□ Legionellosis

□ Pneumonia

If yes, Etiology: _____ Lab Test(s): _____

□ Other Dx: _____

SECTION XII. EXPOSURES

□ Hospitalized before; Date of admission: __ / __ / ____ ; Date of Discharge: __ / __ / ____
□ ICU stay; if yes # of days in ICU___________ days
□ Intubated
Discharge diagnosis: □ Legionellosis □ Pneumonia; etiology:______________________

□ Other diagnosis; specify: _________________________________

□ Hospitalized before; Date of admission: __ / __ / ____ ; Date of Discharge: __ / __ / ____
□ ICU stay; if yes # of days in ICU___________ days
□ Intubated
Discharge diagnosis: □ Legionellosis □ Pneumonia; etiology:______________________

□ Other diagnosis; specify: _________________________________

□ Hospitalized before; Date of admission: __ / __ / ____ ; Date of Discharge: __ / __ / ____
□ ICU stay; if yes # of days in ICU___________ days
□ Intubated
Discharge diagnosis: □ Legionellosis □ Pneumonia; etiology:______________________

□ Other diagnosis; specify: _________________________________

OUTPATIENT VISITS to Hospital A or associated clinics (including rehab visits)

Did patient have any outpatient visits during the 2-10 days prior to symptom onset?
_____ Yes _____ No _____ Unknown

If yes, list location of visits and name of clinic:

Name of Campus	Clinic (e.g., Primary Care, Cardiology)	Building	Room#	Date(s) of Visit