

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

## 2014 LEGIONELLOSIS ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT FORM

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK



- SHADED AREAS FOR OFFICE USE ONLY -

<b>1. STATE:</b> (Residence of Patient) <input type="text"/>	<b>2. COUNTY:</b> (Residence of Patient) <input type="text"/>	<b>3. STATE I.D.:</b> <input type="text"/>	<b>4a. HOSPITAL/LAB I.D. WHERE FIRST CULTURE IDENTIFIED OR FIRST POSITIVE TEST:</b> <input type="text"/>	<b>4b. HOSPITAL I.D. WHERE PATIENT TREATED:</b> <input type="text"/>
--	---	---	---	---

<b>5. STATE HEALTH DEPT. CASE NO.</b> (From CDC Legionellosis case report form for passive surveillance): <input type="text"/>	<b>6. DATE OF SYMPTOM ONSET OF LEGIONELLOSIS:</b> (note this is NOT date of admission) Mo. Day Year <input type="text"/>	<b>7a. WAS PATIENT HOSPITALIZED?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<b>If YES, date of admission:</b> Mo. Day Year <input type="text"/>	<b>Date of discharge:</b> Mo. Day Year <input type="text"/>
--	--	--	---	---

<b>7b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>7c. Did the patient require mechanical ventilation?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>8a. Excluding the current hospitalization, was the patient hospitalized at any time in the 10 days prior to illness onset?</b> If yes, Date of admission: <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Year Date of discharge: <input type="text"/> Mo. <input type="text"/> Day <input type="text"/> Year 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>8b. If YES, hospital I.D.:</b> <input type="text"/>
---	---	--	---

<b>9a. Where was the patient a resident in the 10 days prior to illness onset?</b> (Check all that apply) 1 <input type="checkbox"/> Private residence 1 <input type="checkbox"/> Homeless 1 <input type="checkbox"/> Acute care hospital 1 <input type="checkbox"/> Long term care facility 1 <input type="checkbox"/> Incarcerated 1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Long term acute care facility 1 <input type="checkbox"/> Assisted Living 1 <input type="checkbox"/> Unknown	<b>9b. If resident of a facility, what was the name of the facility?</b> _____	<b>10a. Was patient transferred from another hospital?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>10b. If YES, hospital I.D.:</b> <input type="text"/>
--	---	--	--

<b>11. DATE OF BIRTH:</b> Mo. Day Year <input type="text"/>	<b>12a. AGE:</b> (at time of onset) <input type="text"/>	<b>13. SEX:</b> 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<b>14a. ETHNIC ORIGIN:</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	<b>14b. RACE:</b> (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
<b>12b. Is age in day/mo/yr?</b> 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Yrs.				

<b>15a. WEIGHT:</b> _____ lbs _____ oz OR _____ kg OR <input type="checkbox"/> Unknown	<b>16. TYPE OF INSURANCE:</b> (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
<b>15b. HEIGHT:</b> _____ ft _____ in OR _____ cm OR <input type="checkbox"/> Unknown	
<b>15c. BMI:</b> _____ OR <input type="checkbox"/> Unknown	

<b>17. OUTCOME:</b> 1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown	<b>18. If patient died, was the initial culture or first positive test obtained from autopsy?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
--	---

<b>19. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF ADMISSION?:</b> 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) _____	<b>20. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA?:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No* 9 <input type="checkbox"/> Unknown* <i>*If no or unknown, choose syndrome or infection type:</i> 1 <input type="checkbox"/> Pontiac fever (fever and myalgia without pneumonia) 8 <input type="checkbox"/> Extrapulmonary infection (specify): _____ 9 <input type="checkbox"/> Unknown
--	--

<b>21. Did this patient have a positive flu test 10 days prior to or following a positive Legionella test or positive Legionella culture?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>22. Discharge diagnosis (check all that apply):</b> 1 <input type="checkbox"/> 482.84/A48.1 (Legionnaires' disease) 1 <input type="checkbox"/> 482 (Other bacterial pneumonia) 1 <input type="checkbox"/> 482.3 (Pneumonia due to other specified bacteria) 1 <input type="checkbox"/> 482.83/J15.6 (Other gram-negative bacteria) 1 <input type="checkbox"/> 482.89/J15.8 (Pneumonia due to other specified bacteria) 1 <input type="checkbox"/> 482.9/J15.9 (Bacterial pneumonia unspecified) 1 <input type="checkbox"/> 483 (Pneumonia due to other specified organism) 1 <input type="checkbox"/> 483.8/J16.8 (Pneumonia due to other specified organism) 1 <input type="checkbox"/> 484 (Pneumonia in infectious diseases classified elsewhere) 1 <input type="checkbox"/> 484.8/J17 (Pneumonia in infectious diseases classified elsewhere) 1 <input type="checkbox"/> 485/J18.0 (Bronchopneumonia organism unspecified) 1 <input type="checkbox"/> 486/J18.9 (Pneumonia, organism unspecified) 1 <input type="checkbox"/> None of these listed 1 <input type="checkbox"/> No ICD codes in chart
Public reporting burden of this collection of information is estimated to average 10 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 (0920-0978). 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"/> Premature Birth (specify gestational age at birth) <input type="text"/> (wks) |
| 1 <input type="checkbox"/> Alcohol Abuse, Current                             | 1 <input type="checkbox"/> Dysphagia   | 1 <input type="checkbox"/> Multiple Myeloma        | 1 <input type="checkbox"/> Seizure/Seizure Disorder  |
| 1 <input type="checkbox"/> Alcohol Abuse, Past                                | 1 <input type="checkbox"/> Emphysema/COPD  | 1 <input type="checkbox"/> Multiple Sclerosis      | 1 <input type="checkbox"/> Sickle Cell Anemia  |
| 1 <input type="checkbox"/> Asthma   | 1 <input type="checkbox"/> Heart Failure/CHF   | 1 <input type="checkbox"/> Nephrotic Syndrome      | 1 <input type="checkbox"/> Smoker, Current   |
| 1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD | 1 <input type="checkbox"/> HIV Infection   | 1 <input type="checkbox"/> Neuromuscular Disorder  | 1 <input type="checkbox"/> Smoker, Former  |
| 1 <input type="checkbox"/> Bone Marrow Transplant (BMT)                       | 1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma                                    | 1 <input type="checkbox"/> Obesity                 | 1 <input type="checkbox"/> Solid Organ Malignancy  |
| 1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke            | 1 <input type="checkbox"/> Immunoglobulin Deficiency                                     | 1 <input type="checkbox"/> Other Drug Use, Current | 1 <input type="checkbox"/> Solid Organ Transplant  |
| 1 <input type="checkbox"/> Chronic Kidney Disease                             | 1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation) | 1 <input type="checkbox"/> Other Drug Use, Past    | 1 <input type="checkbox"/> Splenectomy/Asplenia  |
| 1 <input type="checkbox"/> Current Chronic Dialysis                           | 1 <input type="checkbox"/> IVDU, Current   | 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"/> IVDU, Past  | 1 <input type="checkbox"/> Plegias/Paralysis       | 1 <input type="checkbox"/> Other (specify) _____   |
| 1 <input type="checkbox"/> Complement Deficiency                              |  |  |  |
| 1 <input type="checkbox"/> Dementia   |  |  |  |

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> <input type="text"/>
---	--	--	---	---	---	--

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