– LEGIONELLOSIS ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT –

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 –*

OMB No. 0920-0978

**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 ☐ Yes 2 ☐ 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 ☐ Yes
2 ☐ No
9 ☐ Unknown

**7c. Did the patient require mechanical ventilation?**
1 ☐ Yes
2 ☐ No
9 ☐ Unknown

**8a. Excluding the current hospitalization, was the patient hospitalized at any time in the 10 days prior to illness onset?** 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

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 <u>in the 10 days prior to illness onset?</u>** *(Check all that apply)*

1 ☐ Private residence
1 ☐ Long term care facility
1 ☐ Long term acute care facility
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Assisted Living
1 ☐ Acute care hospital
1 ☐ Other (*specify*) _____
1 ☐ Unknown

**9b. If resident of a facility, what was the name of the facility?** _____

**10a. Was patient transferred from another hospital?** 1 ☐ Yes 2 ☐ No 9 ☐ 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 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

**13. SEX:**
1 ☐ Male
2 ☐ Female

**14a. ETHNIC ORIGIN:**
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

**14b. RACE:** *(Check all that apply)*
1 ☐ White
1 ☐ Black
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ Unknown

**15a. WEIGHT:** _____lbs_____ oz **OR** _____ kg **OR** ☐ Unknown

**15b. HEIGHT:** _____ft _____ in **OR** _____ cm **OR** ☐ Unknown

**15c. BMI:** ___ ___.___ **OR** ☐ Unknown

**16. TYPE OF INSURANCE:** *(Check all that apply)*
1 ☐ Private
1 ☐ Medicare
1 ☐ Medicaid/state assistance program
1 ☐ Military
1 ☐ Indian Health Service (IHS)
1 ☐ Incarcerated
1 ☐ Other *(specify)* _____
1 ☐ Uninsured
1 ☐ Unknown

**17. OUTCOME:** 1 ☐ Survived 2 ☐ Died 9 ☐ Unknown

**18. If patient died, was the initial culture or first positive test obtained from autopsy?** 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**19. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF ADMISSION?:**
1 ☐ CT 2 ☐ X-ray 3 ☐ Both 4 ☐ Neither 9 ☐ Unknown

If yes, check all that apply from the radiology report:

1 ☐ Pneumonia/bronchopneumonia
1 ☐ Consolidation
1 ☐ Lobar (NOT interstitial) infiltrate
For pneumonia/consolidation/infiltrate
1 ☐ Single lobar
1 ☐ Multiple lobar infiltrate (unilateral)
1 ☐ Multiple lobar infiltrate (bilateral)
1 ☐ Air space/alveolar density/opacity/disease
1 ☐ Atelectasis
1 ☐ Cavitation
1 ☐ Pleural effusion
1 ☐ Pneumonitis
1 ☐ Pulmonary edema
1 ☐ Interstitial infiltrate
1 ☐ Empyema
1 ☐ ARDS (acute respiratory distress syndrome)
1 ☐ Cannot rule out pneumonia
1 ☐ No evidence of pneumonia
1 ☐ Report not available
1 ☐ Other (*specify*) _____

**20. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA?:**
1 ☐ Yes 2 ☐ No* 9 ☐ Unknown*

**If no or unknown, choose syndrome or infection type:*
1 ☐ Pontiac fever (fever and myalgia without pneumonia)
8 ☐ Extrapulmonary infection (*specify*): _____
9 ☐ Unknown

**21.** Did this patient have a positive flu test 10 days prior to or following a positive *Legionella* test or positive *Legionella* culture?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

**22. Discharge diagnosis (check all that apply):**
1 ☐ 482.84/A48.1 (Legionnaires' disease)
1 ☐ 482 (Other bacterial pneumonia)
1 ☐ 482.3 (Pneumonia due to other specified bacteria)
1 ☐ 482.83/J15.6 (Other gram-negative bacteria)
1 ☐ 482.89/J15.8 (Pneumonia due to other specified bacteria)
1 ☐ 482.9/J15.9 (Bacterial pneumonia unspecified)
1 ☐ 483 (Pneumonia due to other specified organism)
1 ☐ 483.8/J16.8 (Pneumonia due to other specified organism)
1 ☐ 484 (Pneumonia in infectious diseases classified elsewhere)
1 ☐ 484.8/J17 (Pneumonia in infectious diseases classified elsewhere)
1 ☐ 485/J18.0 (Bronchopneumonia organism unspecified)
1 ☐ 486/J18.9 (Pneumonia, organism unspecified)
1 ☐ None of these listed
1 ☐ No ICD codes in chart





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

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

**30. COMMENTS:** _____

_____

## – SURVEILLANCE OFFICE USE ONLY –

**31. Was case first identified through audit?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**32. Was this case also identified through routine passive notifiable disease surveillance?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**33. CRF Status:**
1 ☐ Complete
2 ☐ Incomplete
3 ☐ Edited & Correct
4 ☐ Chart unavailable after 3 requests

**34. Does this case have recurrent disease?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
**If yes, previous (1st) state ID:** ☐☐☐☐☐☐☐

**35. Case status:**
1 ☐ Confirmed
2 ☐ Suspect

**36. Date reported to EIP site:**
Mo. ☐☐ Day ☐☐
Year ☐☐☐☐

**37. Initials of S.O.:** _____

Submitted By: _____ Phone No. : (  )_____ Date:____ /____ /____

Physician's Name: _____ Phone No. : (  )_____