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 in the 10 days prior to illness onset? *(Check all that apply)*
1 ☐ Private residence 1 ☐ Homeless 1 ☐ Acute care hospital
1 ☐ Long term care facility 1 ☐ Incarcerated 1 ☐ Other (*specify*) ______
1 ☐ Long term acute care facility 1 ☐ Assisted Living 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 ☐ Asian
1 ☐ Black 1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ American Indian or Alaska Native 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 ☐ Military 1 ☐ Other *(specify)* ______
1 ☐ Medicare 1 ☐ Indian Health Service (IHS) 1 ☐ Uninsured
1 ☐ Medicaid/state assistance program 1 ☐ Incarcerated 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

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.**

– 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 2 ☐ No 9 ☐ Unknown	___ /___ /___		1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	
25. Culture	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) ________________	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* If yes, list serogroup: 1 ☐ serogroup 1 8 ☐ Other (*specify*) ____________ 9 ☐ Unknown 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ *L.* species, other (*specify*)____________ 9 ☐ *L.* species, unknown or not specified
26. Paired Serology, IFA or ELISA	**Acute** 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	**Acute** ___ /___ /___		**Acute** 1 ☐ Positive If yes, titer: ________ 2 ☐ Negative 9 ☐ Unknown or Indeterminate	**Acute** Species: ________________ Serogroup(s): ____________
	Convalescent 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	**Convalescent** ___ /___ /___		**Convalescent** 1 ☐ Positive If yes, titer: ________ 2 ☐ Negative 9 ☐ Unknown or Indeterminate	**Convalescent** Species: ________________ Serogroup(s): ____________
27. PCR (direct specimen only)	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) ________________	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ *L.* species, other (*specify*)____________ 9 ☐ *L.* species, unknown or not specified
28. DFA (direct fluorescence assay, direct specimen only)	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) ________________	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* If yes, list serogroup: 1 ☐ serogroup 1 8 ☐ Other (*specify*) ____________ 9 ☐ Unknown 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ *L.* species, other (*specify*)____________ 9 ☐ *L.* species, unknown or not specified
29. IHC (immunohistochemistry)	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) ________________	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* If yes, list serogroup: 1 ☐ serogroup 1 8 ☐ Other (*specify*) ____________ 9 ☐ Unknown 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ *L.* species, other (*specify*)____________ 9 ☐ *L.* species, unknown or not specified

30. COMMENTS: ____

– SURVEILLANCE OFFICE USE ONLY –

31. Was case first identified through audit?	32. Was this case also identified through routine passive notifiable disease surveillance?	33. CRF Status:	34. Does this case have recurrent disease?	35. Case status:	36. Date reported to EIP site:	37. Initials of S.O.:
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Complete 2 ☐ Incomplete 3 ☐ Edited & Correct 4 ☐ Chart unavailable after 3 requests	1 ☐ Yes 2 ☐ No 9 ☐ Unknown **If yes, previous (1st) state ID:** ☐☐☐☐☐☐☐	1 ☐ Confirmed 2 ☐ Suspect	Mo. ☐☐ Day ☐☐ Year ☐☐☐☐	________

Submitted By: ______________________________ Phone No. : ( ) ____________ Date:____ /____ /____

Physician's Name: ______________________________ Phone No. : ( ) ____________