**LEGIONELLOSIS CASE REPORT**

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

**CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), ATLANTA, GEORGIA, 30333**

**http://www.cdc.gov/legionella/index.htm**

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**PATIENT INFORMATION**

1. State Health Dept. Case No.: __________________________
2. Reporting State: __________________________
3. County of Residence: __________________________
4. State of Residence: __________________________
5. Occupation: __________________________

6a. Date of Birth: __________ Mo. __________ Day __________ Year  
6b. Age: __________ Years

7. Sex:  
   ☐ Male  ☐ Female

8. Ethnicity:  
   ☐ Hispanic/Latino  ☐ Not Hispanic/Latino  ☐ Unknown

9. Race: (check all that apply)  
   ☐ American Indian/Alaska Native  ☐ Native Hawaiian or Other Pacific Islander  ☐ Asian  ☐ Black or African American  ☐ White  ☐ Unknown

10. Diagnosis: (check one)  
    ☐ Legionnaires’ Disease (pneumonia, clinical or X-ray diagnosed)  
    ☐ Pontiac Fever (fever and myalgia without pneumonia)  
    ☐ Other (e.g., endocarditis, wound infection): __________________________

11. Date of symptom onset of legionellosis: __________ Mo. __________ Day __________ Year

12. Date of first report to public health at any level: __________ Mo. __________ Day __________ Year

13. Was the patient hospitalized during treatment for legionellosis?  
   ☐ Yes  ☐ No  ☐ Unknown

14. Outcome of illness:  
   ☐ Survived  ☐ Died  ☐ Unknown

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**EXPOSURE INFORMATION**

15. In the 10 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?  
   (check one) ☐ Yes  ☐ No  ☐ Unknown

16. In the 10 days before onset, did the patient get in or spend time near a whirlpool spa (i.e., hot tub)?  
   (check one) ☐ Yes  ☐ No  ☐ Unknown

17. In the 10 days before onset, did the patient use a nebulizer, CPAP, BiPAP or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma or for any other reason?  
   (check one) ☐ Yes  ☐ No  ☐ Unknown

18. In the 10 days before onset, did the patient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?  
   (check one) ☐ Yes  ☐ No  ☐ Unknown

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**Public reporting burden of this collection of information is estimated to average 20 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, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address. While your response is voluntary your cooperation is necessary for the understanding and control of this disease.**
19. Was this case associated with a healthcare exposure? (check one)
   1 ☐ Definitely: Patient was hospitalized or a resident of a long term care facility
      for the entire 10 days prior to onset
   2 ☐ No: No exposure to a healthcare facility in the 10 days prior to onset
   3 ☐ Possibly: Patient had exposure to a healthcare facility for a portion
      of the 10 days prior to onset
   8 ☐ Other (specify) ____________________________  9 ☐ Unknown

20. In the 10 days before onset, did the patient visit or stay in an assisted living facility or senior living facility? (check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

<table>
<thead>
<tr>
<th>TYPE OF FACILITY</th>
<th>TYPE OF EXPOSURE</th>
<th>NAME OF FACILITY</th>
<th>CITY</th>
<th>STATE</th>
<th>DATE OF VISIT</th>
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<td></td>
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<td></td>
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<td></td>
<td>START DATE</td>
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<tr>
<td>1 ☐ Assisted Living</td>
<td>1 ☐ Resident</td>
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<td>2 ☐ Visitor or Volunteer</td>
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<td>3 ☐ Employee</td>
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</tr>
<tr>
<td>2 ☐ Senior Living</td>
<td>1 ☐ Resident</td>
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<td>(includes retirement</td>
<td>2 ☐ Visitor or Volunteer</td>
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<td>homes without skilled</td>
<td>3 ☐ Employee</td>
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<td>nursing or personal care)</td>
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</table>

21. Was this case associated with a known outbreak or possible cluster? (check one) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, specify name of facility, city, and state of outbreak: ________________________________

LABORATORY DATA

PLEASE CHECK ALL METHODS OF DIAGNOSIS WHICH APPLY:

1 ☐ CONFIRMED CASE

1 ☐ Urine Antigen Positive: If yes,
   Date Collected: ☐☐☐☐ Mo. Day Year

2 ☐ Culture Positive: If yes,
   Date Collected: ☐☐☐☐ Mo. Day Year
   Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid
   4 ☐ blood 8 ☐ other (specify) ________________________________
   Species: ____________________________ Serogroup: ____________________________

3 ☐ Fourfold rise in antibody titer to Legionella pneumophila serogroup 1: If yes,
   Initial (acute) titer: ___________ Date Collected: ☐☐☐☐ Mo. Day Year
   Convalescent titer: ___________ Date Collected: ☐☐☐☐ Mo. Day Year

2 ☐ SUSPECT CASE

4 ☐ Fourfold rise in antibody titer OTHER THAN Legionella pneumophila serogroup 1 or to multiple species or serogroups of Legionella using pooled antigen: If yes,
   Initial (acute) titer: ___________ Date Collected: ☐☐☐☐ Mo. Day Year
   Convalescent titer: ___________ Date Collected: ☐☐☐☐ Mo. Day Year
   Species: ____________________________ Serogroup: ____________________________

5 ☐ Direct Fluorescent Antibody (DFA) or Immunohistochemistry (IHC) Positive: If yes,
   Date Collected: ☐☐☐☐ Mo. Day Year
   Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid
   4 ☐ blood 8 ☐ other (specify) ________________________________
   Species: ____________________________ Serogroup: ____________________________

6 ☐ Nucleic Acid Assay (e.g., PCR): If yes,
   Date Collected: ☐☐☐☐ Mo. Day Year
   Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions (e.g., sputum, BAL) 3 ☐ pleural fluid
   4 ☐ blood 8 ☐ other (specify) ________________________________
   Species: ____________________________ Serogroup: ____________________________

INTERVIEWER IDENTIFICATION

Interviewer’s Name: ____________________________
Affiliation: ____________________________
Telephone No.: ____________________________
State Health Dept. Official who reviewed this report: ____________________________
Title: ____________________________
Telephone No.: ____________________________

COMMENTS

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____________________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________________

____________________________________________________________ State Health Dept. Case No.: ____________________________
State Health Dept. Official who reviewed this report: ____________________________
Title: ____________________________
Telephone No.: ____________________________

Local Health Dept. Please submit this document to: ______________________________________________________
State/DHD/SSS via your CD clerk

State Health Dept. Return completed form to: ______________________________________________________
Respiratory Diseases Branch, Mailstop C25
Office of Infectious Diseases
Centers for Disease Control and Prevention
1600 Clifton Rd. NE, Atlanta, GA 30333