

Legionellosis Case Report Form

Texas Department of State Health Services Infectious Disease Control Unit 1100 W. 49th St., Austin, Texas 78756 ph: (512) 458-7676 fax: (512) 458-7616

P A T I	Name: Last		First	MI	
	Address:Street		City		
T	County	State	Zip Code	Phone #	
D	DOB:/ Age: Sex	«: O	ccupation:		
A T	Race: W=White; B=Black/African American; N=American Indian/Alaska Native; P=Native Hawaiian/Pacific Islander; A=Asian; O=Other; U=Unknown				
A	Ethnicity: H=Hispanic or Latino; N=not Hispanic or Latino; U=Unknown				
CLI	Onset date:/ Hospitalized:			Symptoms (Check all that apply):	
	Date of admission:/ Date of discharge:/			☐ Fever	
	Name and location of hospital:			Max. temp°F	
N	Physician: Phone: ()			☐ Pneumonia (X-ray diagnosed)	
C A	Primary dx: Legionnaires' disease Pontiac fever Other			☐ Myalgia ☐ Headache	
L D A T A	Outcome: Survived Died Date of death:/			☐ Diarrhea ☐ Cough	
	Reporting source: Hospital Physician Laboratory			☐ Malaise ☐ Chest Pain	
	☐ Patient ☐ State/local/federal agency			☐ Abdominal Pain ☐ Chills	
	Other			☐ Other	
	Date reported to public health://	-			
L A B	Laboratory test(s) performed (Check all that apply):				
	Urine antigen: Positive Negative Specimen source:			Date of collection:/	
	Culture: Positive Negative Specimen source:			Date of collection:/	
D A T A	Species: Serogroup:				
	Antibody: Initial (acute) titer: Serogroup:			Date of collection:/	
	Convalescent titer:	_ Serogroup: _		Date of collection:/	
	Other (specify):				

CASE DEFINITION

A confirmed case has a compatible clinical history and meets at least one of the following laboratory criteria:

- 1) isolation of any Legionella species from lung tissue, respiratory secretions, pleural fluid, blood, or other sterile site
- 2) detection of L. pneumophila, serogroup 1, antigen in urine
- 3) fourfold or greater rise in antibody titer to *L. pneumophila*, serogroup 1, between paired acute and convalescent phase serum **There is no probable case definition for Legionellosis.



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	Is this case associated with an outbreak? Yes No				
	In the 10 days prior to the onset of symptoms, was the patient: Hospitalized? Yes No				
	Name of hospital: Date admitted:/ Date discharged:/				
E P					
I	Resident of a long-term care facility? Yes No Name of facility:				
D E M	In the 10 days prior to the onset of symptoms, did the patient:				
I	Visit a hospital?				
O L	Visit a medical or dental office? Yes No Name of office: Date(s) of visit:				
O G	Travel or stay overnight somewhere other than usual residence? Yes No				
I	Name of lodging City and State Date(s) of stay				
C A					
L					
D					
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A	·				
	Patient risk factors (Check all that apply):				
	☐ Cancer ☐ Chronic lung disease ☐ Diabetes ☐ End-stage renal disease ☐ Smoker				
	# cigarettes per day				
	☐ Treatment with systemic corticosteroids ☐ HIV/AIDS ☐ Transplant ☐ Immunosuppressive condition				
C					
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	Reported by: Phone: ()				
	Investigated by: Investigation Start Date:/				
	Agency: Phone: ()				

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