



Legionellosis Case Report Form

Texas Department of State Health Services
Infectious Disease Control Unit
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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: ____/____/____

Resident of a long-term care facility? Yes No Name of facility: _____

In the 10 days prior to the onset of symptoms, did the patient:

Visit a hospital? Yes No Name of hospital: _____ Date(s) of visit: _____

Visit a medical or dental office? Yes No Name of office: _____ Date(s) of visit: _____

Travel or stay overnight somewhere other than usual residence? Yes No

Name of lodging	City and State	Date(s) of stay
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 _____

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Reported by: _____ Phone: (____) _____ Date Reported: ____/____/____

Investigated by: _____ Investigation Start Date: ____/____/____

Agency: _____ Phone: (____) _____