

Patient's Name: _____ (Last, First, M.I.) _____ (Telephone No.) Hospital: _____
Address: _____ (Number, Street, Apt. No., City, State) _____ (Zip Code) Patient Chart No.: _____

-- Patient identifier information is not transmitted to CDC --



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333

LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY LEGIONELLA SPECIES)



Form Approved OMB No. 0920-0009

- PATIENT INFORMATION -

1. State Health Dept. Case No. _____	2. Reporting State: [][]	3. (CDC Use Only) Case No. [][][][][][][][][][]	4. County of Residence _____	5. State of Residence [][]	6. Occupation: _____
---	-------------------------------	--	---------------------------------	---------------------------------	-------------------------

7a. Date of Birth: Mo. [][] Day [][] Year [][][][]	7b. Age: [][][] 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Years	8. Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	9. Ethnicity: 1 <input type="checkbox"/> Hispanic/Latino 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> Not Hispanic/Latino	10. Race: 1 <input type="checkbox"/> American Indian/Alaskan Native 2 <input type="checkbox"/> Asian	3 <input type="checkbox"/> Black or African American 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> White 9 <input type="checkbox"/> Unk
---	---	---	--	--	---

11. Possible sources of exposure:
IN THE TWO WEEKS BEFORE ONSET, DID PATIENT:

a) Travel or stay overnight somewhere other than usual residence? CITY _____ LODGING _____
1 Yes 2 No 9 Unk
If Yes, give cities and lodging where available: _____

* For suspected travel related cases, please contact CDC or pertinent state health departments immediately.

b) Have dental work? 1 Yes 2 No 9 Unk If Yes, name of dental office: _____

c) Visit a hospital as an outpatient? 1 Yes 2 No 9 Unk If Yes, name of hospital: _____

d) Work in a hospital? 1 Yes 2 No 9 Unk If Yes, name of hospital: _____

12. Was case hospital related (nosocomial)?

2 Not nosocomial: No inpatient or outpatient hospital visits in the 10 days prior to onset of symptoms. 3 Possibly nosocomial: Patient hospitalized 2 - 9 days before onset of legionella infection. 9 Unk

1 Definitely nosocomial: Patient hospitalized continuously for ≥ 10 days before onset of legionella infection. 8 Other (Specify) _____

13. Was this patient's legionella infection: (check one)

1 Associated with outbreak (Specify location): _____

2 Sporadic case 9 Unk

- CLINICAL ILLNESS -

14. Diagnosis: (check one)

1 Legionnaires' Disease (Pneumonia, X-ray diagnosed) 8 Other (Specify) _____

2 Pontiac fever (fever, myalgia without pneumonia) 9 Unk

15. Date of symptom onset of Legionellosis Mo. [][] Day [][] Year [][][][]	16. Was patient hospitalized for Legionellosis? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk Hospital name: _____ Hospital address: _____	17. Outcome of illness: 1 <input type="checkbox"/> Survived 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> Died
---	---	--

- CASE DEFINITION -

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

- 1) isolation of *Legionella* species from lung tissue, respiratory secretions, pleural fluid, blood or other sterile site
- 2) demonstration of *L. pneumophila*, serogroup 1, in lung tissue, respiratory secretions, or pleural fluid by direct fluorescent antibody testing
- 3) fourfold or greater rise in immunofluorescent antibody titer to *L. pneumophila*, serogroup 1, to 128 or greater
- 4) detection of *L. pneumophila* serogroup 1 antigen in urine

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.

