

# Legionellosis

Agency: \_\_\_\_\_

Investigator: \_\_\_\_\_

Phone number: \_\_\_\_\_

### FOR STATE USE ONLY

Status:  Confirmed  Probable  
 Suspect  Not a case

Reviewer initials: \_\_\_\_\_

Referred to another state: \_\_\_\_\_

## CASE

Last name: \_\_\_\_\_  
First and middle name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Estimated?  Age: \_\_\_\_\_

Maiden name: \_\_\_\_\_ Suffix: \_\_\_\_\_

Gender:  Female  Male  Other \_\_\_\_\_

Address line: \_\_\_\_\_

Pregnant:  Yes  No  Unk Est. delivery date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Zip: \_\_\_\_\_ City: \_\_\_\_\_

Marital status:  Single  Married  Divorced  Parent with partner  Separated  Widowed

State: \_\_\_\_\_ County: \_\_\_\_\_

Race:  American Indian or Alaskan Native  Unknown  
 Black or African American  White  
 Hawaiian or Pacific Islander  Asian

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown

Long-term care resident:  Yes  No  Unknown

Parent/Guardian name: \_\_\_\_\_

Facility name: \_\_\_\_\_

Parent/Guardian phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

## EVENT

Disease type  Legionnaires Disease  Pontiac Fever

Diagnosis date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Onset date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Last name: \_\_\_\_\_

Event outcome:  Survived this illness  Died from this illness  
 Died unrelated to this illness  Unknown

First name: \_\_\_\_\_

Date of Death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Provider title:  ARNP  MD  PA  
 DO  NP

Event exception:  Case could not be found  
 Case could not be interviewed  
 Case refused interview  
 Other – see notes

Outbreak related:  Yes  No  Unknown

Outbreak name: \_\_\_\_\_

Facility name: \_\_\_\_\_

Exposure setting: \_\_\_\_\_

Address line 1: \_\_\_\_\_

Epi-linked:  Yes  No  Unknown

Address line 2: \_\_\_\_\_

Location acquired:  In USA, in reporting state  
 In USA, outside reporting state  
 Outside USA  
 Unknown

Zip code: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Country: \_\_\_\_\_

State: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_ Type: \_\_\_\_\_

Healthcare provider information

## LABORATORY FINDINGS

Laboratory: \_\_\_\_\_

Accession #: \_\_\_\_\_

Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Specimen source: \_\_\_\_\_

Test type: \_\_\_\_\_

Result type:  Preliminary  Final

Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Result:  Positive  Negative

Organism: \_\_\_\_\_ Serogroup: \_\_\_\_\_

Other \_\_\_\_\_

Laboratory: \_\_\_\_\_

Accession #: \_\_\_\_\_

Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Specimen source: \_\_\_\_\_

Test type: \_\_\_\_\_

Result type:  Preliminary  Final

Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Result:  Positive  Negative

Organism: \_\_\_\_\_ Serogroup: \_\_\_\_\_

Other \_\_\_\_\_

Laboratory: \_\_\_\_\_

Accession #: \_\_\_\_\_

Collection date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Specimen source: \_\_\_\_\_

Test type: \_\_\_\_\_

Result type:  Preliminary  Final

Result date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Result:  Positive  Negative

Organism: \_\_\_\_\_

Serogroup \_\_\_\_\_

Other \_\_\_\_\_

**OCCUPATIONS**

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Job title: _____
Date worked from: ____ / ____ / ____	Facility name: _____
Date worked to: ____ / ____ / ____	Address: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Zip code: _____
Date removed: ____ / ____ / ____	City: _____ State: _____ County: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Phone: (____) - ____ - ____ Type: _____
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____

Occupation type: Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Job title: _____
Date worked from: ____ / ____ / ____	Facility name: _____
Date worked to: ____ / ____ / ____	Address: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Zip code: _____
Date removed: ____ / ____ / ____	City: _____ State: _____ County: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Phone: (____) - ____ - ____ Type: _____
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____

**HOSPITALIZATIONS**

Was the case hospitalized?  Yes  No  Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

**CLINICAL INFO & DIAGNOSIS**

<b>Symptoms</b>	Fever: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Onset date: ____ / ____ / ____	Highest known fever: _____ <input type="checkbox"/> Celsius <input type="checkbox"/> Fahrenheit
	Abdominal pain <input type="checkbox"/>	Headache <input type="checkbox"/>	
	Anorexia <input type="checkbox"/>	Malaise <input type="checkbox"/>	
	Cough <input type="checkbox"/>	Muscle pain <input type="checkbox"/>	
	Diarrhea <input type="checkbox"/>	Pneumonia <input type="checkbox"/>	
	Fever <input type="checkbox"/>	Shortness of breath <input type="checkbox"/>	

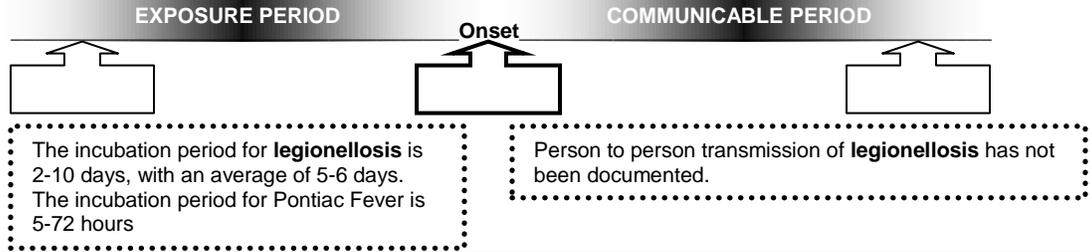
**TREATMENT**

Antibiotics prescribed?  Yes  No  Unknown

Antibiotic: _____ Date started: ____ / ____ / ____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____ / ____ / ____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____ / ____ / ____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____
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**INFECTION TIMELINE**

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



**RISK FACTORS/TRAVEL**

Traveled within Iowa?  Yes  No  Unk City in Iowa: \_\_\_\_\_ Departure date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Return date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Traveled within U.S.?  Yes  No  Unk State: \_\_\_\_\_ City: \_\_\_\_\_ Departure date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Return date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Traveled outside U.S.?  Yes  No  Unk Country: \_\_\_\_\_ Departure date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Return date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have dialysis:  Yes  No  Unknown

Visit a hospital:  Yes  No  Unknown Date visited: \_\_\_\_/\_\_\_\_/\_\_\_\_

Facility name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_ County: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext: \_\_\_\_\_ Type: \_\_\_\_\_

**Water exposures**

Went swimming?  Yes  No  Unknown

If Yes, complete the table below:

Types:  Hot tub/spa  Lake  Water park  Hotel/motel  Outdoor private

Kiddie pool  Pond  Swimming pool  Indoor private  Outdoor public

River/stream  Water fountain/splash pad  Indoor public

Facility names: \_\_\_\_\_ Date(s) swam: \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

**Other exposures**

Worked with a Case:  Yes  No  Unknown From date: \_\_\_\_/\_\_\_\_/\_\_\_\_ To date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Lived with another Case:  Yes  No  Unknown From date: \_\_\_\_/\_\_\_\_/\_\_\_\_ To date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Received organ transplant:  Yes  No  Unknown Date received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Organ type: \_\_\_\_\_

Cancer:  Yes  No  Unknown From date: \_\_\_\_/\_\_\_\_/\_\_\_\_ To date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Received radiation therapy:  Yes  No  Unknown From date: \_\_\_\_/\_\_\_\_/\_\_\_\_ To date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Received chemotherapy:  Yes  No  Unknown From date: \_\_\_\_/\_\_\_\_/\_\_\_\_ To date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Smoked cigarettes:  Yes  No  Unknown Packs per day:  >2 packs a day  1 to 2 packs a day  Less than a pack a day

**NOTES:**

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