WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Legionellosis

PATIENT DEMOGRAPHICS

Name (last, first): _____

Address (mailing): _____

Address physical): _____

City/State/Zip: _____

Phone (home): _____ **Phone** (work/cell) : _____

Occupation _____

Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*

Name: _____ *Phone:* _____

Birth date: __ / __ / ____ **Age**: _____

Gender: ☐Male ☐Female ☐Unk

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

Race: (mark all that apply)

☐White ☐Black/Afr. Amer. ☐ Asian
☐ Native HI/Other PI ☐ Am. Ind/AK Native
☐Other ☐Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____

Investigation Start Date: __ / __ / ____

Earliest date reported to LHD: __ / __ / ____

Earliest date reported to State: __ / __ / ____

Entered in WVEDSS? ☐Yes ☐No ☐Unk

Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐Private Provider ☐Public Health Agency ☐Other_____

Reporter Name: _____ **Reporter Phone** : _____

Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

Diagnosis

Y	N	U	
☐	☐	☐	Legionnaires' Disease (Pneumonia, x-ray or clinical diagnosed)
☐	☐	☐	Pontiac Fever (Fever, myalgia without pneumonia)
☐	☐	☐	Extrapulmonary site/location: _____

Predisposing Factors

☐	☐	☐	Smokes tobacco
☐	☐	☐	Chronic liver disease
☐	☐	☐	Immunosuppressive therapy or disease
☐	☐	☐	Chronic diabetes
☐	☐	☐	Chronic lung disease
☐	☐	☐	Underlying illness, Specify: _____

Signs and Symptoms

Y	N	U		Y	N	U	
☐	☐	☐	Fever	☐	☐	☐	Myalgia (muscle pain)
☐	☐	☐	Cough	☐	☐	☐	Chest Pain
☐	☐	☐	Headache	☐	☐	☐	Malaise
☐	☐	☐	Chills	☐	☐	☐	Abdominal pain
☐	☐	☐	Vomiting	☐	☐	☐	Diarrhea
☐	☐	☐	Confusion	☐	☐	☐	Shortness of breath
☐	☐	☐	Other: _____				

☐ ☐ ☐ Hospitalized for this illness
Hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

Outcome
☐ Survived ☐ Still Ill
☐ Died due to this illness Date of death: __ / __ / ____
☐ Unknown

LABORATORY (Please submit copies of <u>all</u> labs associated with this illness to DIDE)

Specimen source: _____ Collection date: __ / __ / ____

Y	N	U	
☐	☐	☐	*Legionella* organism isolated from lower respiratory secretion, lung tissue. Pleural fluid or extrapulmonary site. Species _____
☐	☐	☐	*L. pneumophila* serogroup 1 antigen detected in urine.
☐	☐	☐	*Legionella* species detected from lower respiratory secretion, lung tissue, pleural fluid or extrapulmonary site by PCR or nucleic acid test.
☐	☐	☐	4-fold or greater rise in antibody titer to (check all that apply):

Titer values: Initial (acute)_____Date_____ Convalescent _____ Date_____
☐ *L. pneumophila* serogroup 1 ☐ A species or serotype of *Legionella* **other than** *L. pneumophila* serogroup 1
☐ Multiple species of *Legionella* using pooled antigens

☐ ☐ ☐ Detection of *Legionella* in lower respiratory secretion, lung tissue, pleural fluid or extrapulmonary site by DFA staining, IHC or similar test.

☐ ☐ ☐ Epi-linked with no lab testing performed

INFECTION TIMELINE

Instructions: Enter onset date in grey box. Count backward to determine probable exposure period

	Exposure period		Onset date
***Days** from onset*	***-14 (Max Incubation)***	***-1 (Min Incubation)***	
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

EPIDEMIOLOGIC EXPOSURES

Travel History

Y N U **In the 14 days before onset**, did the patient send any nights away from home (excluding healthcare settings)?

☐ ☐ ☐ If yes, complete table below:

Accommodation name	Address, city, state, zip, country	Room #	Arrival date	Departure date

Other Exposure History

Y N U **In the 14 days before onset did the patient:**

☐ ☐ ☐ Get in or spend time near a whirlpool spa/ hot tub /jacuzzi? Location: _____

☐ ☐ ☐ Use a nebulizer, CPAP, BiPAP of any other respiratory therapy device for the treatment of sleep apnea, COPD or asthma?

☐ ☐ ☐ does this device have a humidifier? What type of water is used? Sterile / distilled /bottled /tap / well/ other

☐ ☐ ☐ Have exposures to aerosolized water (e.g. fountains, misters, sprinklers)? Location:_____

☐ ☐ ☐ Have recreational water exposures (e.g., lakes, rivers, pools, spray pads) Location:_____

☐ ☐ ☐ Have exposures to soil (gardening, potting soil, excavation, etc.)? Location:_____

☐ ☐ ☐ Have exposures to remodeling or construction near home or work ? Location:_____

☐ ☐ ☐ Other exposures:_____

Healthcare Associated Exposures

☐ ☐ ☐ **In the 14 days before onset**, did the patient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)? If yes, complete table below:

☐ ☐ ☐ Was the healthcare facility a transplant center? (if more than one facility was visited, please list all transplant centers)

Type of setting: H = Hospital, **LTC** = Long Term Care, **C** = Clinic **O** = Other
Type of exposure: IP = Inpatient, **OP** = Outpatient, **R** = Resident, **V** = Visitor/volunteer, **E** = Employee
Type of facility: AL = Assisted living facility, **SL** = Senior living facility (no skilled personal care)

Type of setting **H LTC C O**	Type of exposure **IP OP V E**	Name of facility	Reason for visit	City, state	Start date	End date
☐ ☐ ☐ ☐	☐ ☐ ☐ ☐					
☐ ☐ ☐ ☐	☐ ☐ ☐ ☐					

Y N U **In the 14 days before onset**, did the patient visit or stay at a nursing home, assisted living facility or senior living facility? If yes, complete table below:

☐ ☐ ☐

Type of facility **AL SL**	Type of exposure **R V E**	Name of facility	City, state	Start date	End date
☐ ☐	☐ ☐ ☐				
☐ ☐	☐ ☐ ☐				

Was the case hospital related (nosocomial)? specify below:

☐ Not nosocomial: No inpatient or outpatient hospital visits in the 10 days prior to onset of symptoms

☐ Definitely nosocomial: Patient hospitalized continuously for >= 10 days before onset of legionella infection

☐ Possibly nosocomial: Patient hospitalized 2-9 days before onset of legionella infection

☐ Other (Specify) _____

☐ Unknown

This patient's legionella infection was: (check one) ☐ Sporadic Case ☐ Outbreak related ☐ Unknown

PUBLIC HEALTH ISSUES

Y	N	NA	
☐	☐	☐	Possible travel associated case
☐	☐	☐	Possible or definite hospital associated case
☐	☐	☐	Knows persons experiencing similar symptoms
☐	☐	☐	Case is part of an outbreak OB # :

☐ ☐ ☐ Case is an epi-link to confirmed/suspected source of Legionella. specify source:

PUBLIC HEALTH ACTIONS

Y	N	NA	
☐	☐	☐	Disease/transmission education provided
☐	☐	☐	Notified DIDE of travel history
☐	☐	☐	Coordinated investigation with healthcare facility
☐	☐	☐	Patient is lost to follow-up