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**: __ / __ / ____

### Clinical Findings

Y N U

☐ ☐ ☐ Legionnaires' Disease (Pneumonia, x-ray diagnosed)

☐ ☐ ☐ Pontiac Fever (Fever, myalgia without pneumonia)

☐ ☐ ☐ Admitted to intensive care unit

☐ ☐ ☐ Mechanical ventilation or intubation required

### 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

☐ ☐ ☐ Fever

☐ ☐ ☐ Cough

☐ ☐ ☐ Headache

☐ ☐ ☐ Chills

☐ ☐ ☐ Vomiting

☐ ☐ ☐ Other:______________________________

Y N U

☐ ☐ ☐ Myalgia (muscle pain)

☐ ☐ ☐ Chest Pain

☐ ☐ ☐ Malaise

☐ ☐ ☐ Abdominal pain

☐ ☐ ☐ Diarrhea

☐ ☐ ☐ Hospitalized for this illness

Hospital name:______________________________

Admit date: __ / __ / ____ Discharge date: __ / __ / ____

**Death**

☐ ☐ ☐ Died due to this illness Date of death: __ / __ / ____

## LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

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

Y N U

☐ ☐ ☐ Legionella culture (normally sterile site) Species______________________________

☐ ☐ ☐ L. pneumophilla serogroup 1 antigen detected in urine

☐ ☐ ☐ L. pneumophilla serogroup 1 serum antibody titer with >= 4 fold rise (acute and convalescent serum pair)

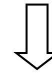
☐ ☐ ☐ Titer to Legionella species/serogroups other than L. pneumophilia serogroup 1, >= 4 fold rise

☐ ☐ ☐ Legionella antigen or organism detected by DFA, Immunohistochemistry, or other method in respiratory secretions

☐ ☐ ☐ Legionella species detected by validated nucleic acid assay

## 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 10 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 10 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:___________________________________

### Healthcare Associated Exposures

☐ ☐ ☐ **In the 10 days before onset**, did the patient visit or stay at a healthcare setting (e.g., hospital, rehab facility, clinic, dental office)? 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, **R** = Rehab, **C** = Clinic, **D** = Dental **O** = Other
**Type of exposure:** **IP** = Inpatient, **OP** = Outpatient, **R** = Resident, **Vi** = Visitor, **E** = Employee, **Vo** = Volunteer
**Type of facility:** **NH** = Nursing home (skilled personal care), **AL** = Assisted living facility, **SL** = Senior living facility (no skilled personal care)

| Type of setting H R C D O | Type of exposure IP OP Vi E Vo | Name of facility | Reason for visit | City, state | Dates |
|---|---|---|---|---|---|
| ☐☐☐☐☐ | ☐☐☐☐☐ | | | | |
| ☐☐☐☐☐ | ☐☐☐☐☐ | | | | |

Y N U

☐ ☐ ☐ **In the 10 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 NH AL SL | Type of exposure R Vi E Vo | Name of facility | City, state | Dates |
|---|---|---|---|---|
| ☐ ☐ ☐ | ☐☐☐☐ | | | |
| ☐ ☐ ☐ | ☐☐☐☐ | | | |

**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

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

☐ Definitely nosocomial: Patient hospitalized continuously for >= 10 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 # : |

## 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 |
| ☐ ☐ ☐ | Other:______________________________ |