



Legionellosis

County _____

Case name (last, first) _____
 Birth date ___/___/___ Age at symptom onset _____ Years Months
 Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: Investigation start ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ Case complete ___/___/___

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply)

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (*specify*: Amer Ind *and/or* AK Native) Asian Black or African American
 Native HI/Pacific Islander (*specify*: Native HI *and/or* Pacific Islander) White Patient declined to respond Unk

Additional race information:

- Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese
- Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian
- Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong
- Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen
- Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo
- Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo
- Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali
- South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian
- Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

- Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese
- Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese
- Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco
- Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan
- Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya
- Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____
 Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk
 Diagnosed as Legionnaires' Disease (pneumonia, clinical or X-ray diagnosed)
 Pontiac Fever (fever and myalgia without pneumonia)
 Extrapulmonary Legionellosis _____

Clinical Features

Y N Unk

Any fever, subjective or measured Temp measured Yes No Highest measured temp _____°F

Cough

Myalgia (muscles aches or pains)

Pneumonia Diagnosed by X-Ray CT MRI Provider Only
 Result Positive Negative Indeterminate Not tested Other _____

Predisposing Conditions

Y N Unk

Chronic liver disease

Y N Unk

Chronic lung disease (e.g., COPD, emphysema)

Current tobacco smoker

Diabetes mellitus

Immunosuppressive therapy or condition, or disease _____

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Mechanical ventilation or intubation required

Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*

Autopsy performed

Disease on death certificate as cause or contributor

Location of death Outside of hospital (e.g., home or in transit to the hospital) Emergency department (ED)

Inpatient ward ICU Other _____

RISK AND RESPONSE (Ask about exposures in the 14 days before symptom onset)**Risk and Exposure Information****Associated with a health care exposure**

Presumptive: Patient had 10 or more days of continuous stay at a health care facility during the 14 days before onset of symptoms

Facility notified Yes No Unk

Possibly: Patient had exposure to a health care facility for a portion of the 14 days prior to onset

Facility notified Yes No Unk

No: No exposure to a health care facility in the 14 days prior to onset

Unk

Other _____

Y N Unk

(Potential) Occupational exposure

In the 14 days before symptom onset,

Y N Unk

Did the patient get in or spend time near a whirlpool spa (i.e. hot tub)?

Date (record all) ___/___/___ Where _____

Did the patient take a cruise?

Name of vessel, departure and return dates, port(s) of entry and exit _____

Did the patient have any recreational water exposure (e.g., lake, river, pool, wading pool, fountain)?

Date (record all) ___/___/___ Where _____

Recreational water exposure Ocean, lake, pond, river, stream

Pool, wading pool, water park, splash pool, spa, hot tub, fountain

Both

Did the patient have any other aerosolized water exposure (e.g., fountains, spas, humidifier, hot tub)?

Did the patient have soil exposure (e.g., gardening, potting soil, construction)?

Did the patient use a nebulizer, CPAP, BiPAP or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma or for any other reason?

Does this device use a humidifier?

What type of water is used in this device (check all that apply) Sterile Distilled Bottled Tap
 Unk Other _____

Y N Unk

Did the patient have a history of spending at least one night away from home, either in the same country of residence or abroad (excluding health care settings)?

	Setting 1	Setting 2	Setting 3
Accommodation name			
Address			
City, State, Zip			
Country			
Room Number			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Did the patient visit or stay in a health care setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?

	Setting 1	Setting 2	Setting 3
Name of facility			
Type of health care setting/facility (check one)	<input type="checkbox"/> Hospital <input type="checkbox"/> Long term care <input type="checkbox"/> Clinic <input type="checkbox"/> Other _____	<input type="checkbox"/> Hospital <input type="checkbox"/> Long term care <input type="checkbox"/> Clinic <input type="checkbox"/> Other _____	<input type="checkbox"/> Hospital <input type="checkbox"/> Long term care <input type="checkbox"/> Clinic <input type="checkbox"/> Other _____
Type of exposure (check one)	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee
Is this facility also a transplant center	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Reason for visit			
City, State			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Did the patient visit or stay in an assisted living facility or senior living facility?

	Setting 1	Setting 2	Setting 3
Name of facility			
Type of facility	<input type="checkbox"/> Assisted living facility <input type="checkbox"/> Senior living facility <input type="checkbox"/> Unk	<input type="checkbox"/> Assisted living facility <input type="checkbox"/> Senior living facility <input type="checkbox"/> Unk	<input type="checkbox"/> Assisted living facility <input type="checkbox"/> Senior living facility <input type="checkbox"/> Unk
Type of exposure (check one)	<input type="checkbox"/> Resident <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee	<input type="checkbox"/> Resident <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee	<input type="checkbox"/> Resident <input type="checkbox"/> Visitor or volunteer <input type="checkbox"/> Employee
City, State			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Community exposures in the 14 days before symptom onset

Y N Unk

Did the patient shower away from home?

	Setting 1	Setting 2	Setting 3
Location name			
Location address			
Describe exposure			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Was the patient near a mister (e.g grocery store produce mister, outdoor restaurant mister, etc)?

	Setting 1	Setting 2	Setting 3
Facility name			
Facility address			
Describe exposure			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Was the patient near a sprinkler?

	Setting 1	Setting 2	Setting 3
Location name			
Location address			
Describe exposure			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Did the patient attend a convention, reception, conference, or other public gathering?

	Setting 1	Setting 2	Setting 3
Facility name			
Facility address			
Describe exposure			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Did the patient visit or live in a congregate living facility (e.g., correctional facilities, shelters, dormitories, etc.)?

	Setting 1	Setting 2	Setting 3
Facility name			
Facility address			
Describe exposure			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Did the patient visit an area with large buildings (e.g., shopping centers, high-rise complexes, etc.) that may have a cooling tower(s)?

	Setting 1	Setting 2	Setting 3
Facility name			
Facility address			
Describe exposure			
Start and end dates	/ / to / /	/ / to / /	/ / to / /

Y N Unk

Was the patient around construction/remodeling near home or place visited?

	Setting 1	Setting 2	Setting 3
Facility name			
Facility address			
Describe exposure			
Start and end dates	____ / ____ / ____ to ____ / ____ / ____	____ / ____ / ____ to ____ / ____ / ____	____ / ____ / ____ to ____ / ____ / ____

Occupational exposures in the 14 days before symptom onset (*leave blank if patient is not employed*)

Y N Unk

Does the patient work on water device/system maintenance (e.g., cooling towers, plumbing, hot tub)?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Facility Name _____

Facility Address _____

Describe Exposure _____

Y N Unk

Does the patient work in water-related leisure (e.g., hotels, cruise ships, water parks)?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Facility Name _____

Facility Address _____

Describe Exposure _____

Y N Unk

Does the patient work in an industrial/manufacturing plant with a water spray cooling system or processes involving spraying water?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Facility Name _____

Facility Address _____

Describe Exposure _____

Y N Unk

Does the patient work in commercial or long haul truck driving?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Describe Exposure _____

Y N Unk

Does the patient work in a commercial kitchen?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Facility Name _____

Facility Address _____

Describe Exposure _____

Y N Unk

Does the patient work in custodial services (e.g., housekeeping, janitorial)?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Facility Name _____

Facility Address _____

Describe Exposure _____

Y N Unk

Does the patient work in construction (e.g., spraying water, demolition, refurbishing)?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Facility Name _____

Facility Address _____

Describe Exposure _____

Y N Unk

Does the patient work at a wastewater treatment plant?

Start Date ____ / ____ / ____ End Date ____ / ____ / ____

Facility Name _____

Facility Address _____

Describe Exposure _____

Y N Unk

Does the patient work in another occupation involving water exposures (please describe)?

Start Date ___/___/___ End Date ___/___/___

Facility Name _____

Facility Address _____

Describe Exposure _____

Exposure and Transmission Summary

Y N Unk

Epidemiologic link to a setting with a confirmed source of Legionella (e.g., positive environmental sampling result associated with a cruise ship, public accommodation, cooling tower, etc.) **OR** to a setting with a suspected source of Legionella that is associated with at least one confirmed case

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure setting Daycare/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____

Describe _____

Exposure summary

Public Health Interventions/Actions

Y N Unk

Letter sent Date ___/___/___ Batch date ___/___/___

NOTES

LAB RESULTS

Lab report information

Lab report reviewed – LHJ

WDRS user-entered lab report note

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen

Specimen identifier/accession number _____

Specimen collection date ___/___/___ **Specimen received date** ___/___/___

WDRS specimen type _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result

WDRS test performed _____

WDRS test result, coded _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed Pending

Test result status Final results; Can only be changed with a corrected result

- Preliminary results
- Record coming over is a correction and thus replaces a final result
- Results cannot be obtained for this observation
- Specimen in lab; results pending

Result date ___/___/___

Upload document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.