Washington State Department of Health

Legionellosis

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other 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
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

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

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

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

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

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 _____

REPORT SOURCE

Initial report source _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

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 _____
Contact name _____
Contact phone _____

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)
☐ Other (endocarditis, wound infection) _____

Clinical Features

Y	N	Unk	
☐	☐	☐	**Any fever**, subjective or measured Temp measured ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**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

Legionellosis required variables are in **bold.** Answers are: Yes, No, Unknown to case

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 10 days before symptom onset)

Risk and Exposure Information

Associated with a health care exposure
☐ Definitely: Patient was hospitalized or a resident of a long term care facility for the entire 10 days prior to onset
Facility notified ☐ Yes ☐ No ☐ Ukn
☐ Possibly: Patient had exposure to a health care facility for a portion of the 10 days prior to onset
Facility notified ☐ Yes ☐ No ☐ Ukn
☐ No: No exposure to a health care facility in the 10 days prior to onset
☐ Unk
☐ Other _____

Y N Unk
☐ ☐ ☐ (Potential) Occupational exposure

In the 10 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)	☐ Hospital ☐ Long term care ☐ Clinic ☐ Other _____	☐ Hospital ☐ Long term care ☐ Clinic ☐ Other _____	☐ Hospital ☐ Long term care ☐ Clinic ☐ Other _____
Type of exposure (check one)	☐ Inpatient ☐ Outpatient ☐ Visitor or volunteer ☐ Employee	☐ Inpatient ☐ Outpatient ☐ Visitor or volunteer ☐ Employee	☐ Inpatient ☐ Outpatient ☐ Visitor or volunteer ☐ Employee
Is this facility also a transplant center	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ 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	☐ Assisted living facility ☐ Senior living facility ☐ Unk	☐ Assisted living facility ☐ Senior living facility ☐ Unk	☐ Assisted living facility ☐ Senior living facility ☐ Unk
Type of exposure (check one)	☐ Resident ☐ Visitor or volunteer ☐ Employee	☐ Resident ☐ Visitor or volunteer ☐ Employee	☐ Resident ☐ Visitor or volunteer ☐ Employee
City, State			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Exposure and Transmission Summary

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 _____