



# 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 ___/___/___

**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 \_\_\_\_\_

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