



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)

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 RESULTSLab 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 PendingTest 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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____