Washington State Department of HEALTH

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 childs) 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

Case Name _____ LHJ Case ID _____

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 _____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
☐	☐	☐	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 ☐ Ukn
☐ Possibly: Patient had exposure to a health care facility for a portion of the 14 days prior to onset
Facility notified ☐ Yes ☐ No ☐ Ukn
☐ 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)	☐ 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

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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