

Patient's Name (Last, First, MI): \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Address (Number, Street, Apt No., City, State, ZIP): \_\_\_\_\_

Patient Chart No.: \_\_\_\_\_ **\*\*\*PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC\*\*\***



## National Center for Immunization and Respiratory Diseases

# LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY *LEGIONELLA* SPECIES)

U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention (CDC), Atlanta, Georgia 30329  
<https://www.cdc.gov/legionella/index.html>

Form Approved  
OMB No. 0920-0728

**CDC Use Only**  
Case No.: \_\_\_\_\_

1. State health dept. case no.:	2. Reporting state:	3. City of residence:	4. County of residence:	5. State of residence:
6. Industry:	7. Occupation:	8a. Date of birth (mm/dd/yyyy):	8b. Age: Days Months Years	9. Sex: Male Female Unknown
10. Ethnicity: Hispanic/Latino Not Hispanic/Latino Unknown	11. Race (check all that apply): American Indian/Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White Unknown	12. Diagnosis: Legionnaires' disease (pneumonia, clinical or X-ray diagnosed) Pontiac fever (fever and myalgia without pneumonia) Extrapulmonary legionellosis (specify location):		
13. Date of symptom onset of legionellosis (mm/dd/yyyy):		14. Date of first report to public health at any level (mm/dd/yyyy):		
15. Was the patient hospitalized during treatment for legionellosis? Yes No Unknown	If yes, date of admission (mm/dd/yyyy): Hospital name: City, state:		16. Outcome of illness: Survived Died Still ill Unknown	

17. In the 14 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?  
Yes No Unknown

If yes, please complete the following information:

<b>Name of accomodation 1:</b> _____ Street address: _____ Room number: _____ City: _____ State: _____ ZIP: _____ Country: _____ Date of arrival: _____ Date of departure: _____ Comments about travel: _____
<b>Name of accomodation 2:</b> _____ Street address: _____ Room number: _____ City: _____ State: _____ ZIP: _____ Country: _____ Date of arrival: _____ Date of departure: _____ Comments about travel: _____

**\*To add additional accomodations, see page 7.**

18. In the 14 days before onset, did the patient visit or stay in a healthcare setting (e.g., hospital, long-term care/rehab/skilled nursing facility, clinic)?  
Yes No Unknown

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address. While your response is voluntary your cooperation is necessary for the understanding and control of this disease.

If yes, please complete the following information:

**Name of healthcare facility 1:** \_\_\_\_\_

Type of healthcare setting/facility:		Type of exposure:		Is this facility also a transplant center?
Hospital	Other, specify: _____	Inpatient	Unknown	Yes
Long-term care		Outpatient	Other, specify: _____	No
Clinic		Visitor or volunteer		Unknown
Unknown		Employee		

Street address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Date of arrival: \_\_\_\_\_ Date of departure: \_\_\_\_\_ Did the healthcare facility have in place a water management program to reduce the risk of *Legionella* growth and spread? Yes No Unknown

Comments about healthcare facility: \_\_\_\_\_

**Name of healthcare facility 2:** \_\_\_\_\_

Type of healthcare setting/facility:		Type of exposure:		Is this facility also a transplant center?
Hospital	Other, specify: _____	Inpatient	Unknown	Yes
Long-term care		Outpatient	Other, specify: _____	No
Clinic		Visitor or volunteer		Unknown
Unknown		Employee		

Street address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Date of arrival: \_\_\_\_\_ Date of departure: \_\_\_\_\_ Did the healthcare facility have in place a water management program to reduce the risk of *Legionella* growth and spread? Yes No Unknown

Comments about healthcare facility: \_\_\_\_\_

**\*To add additional healthcare facilities, see page 7.**

19. Was this case associated with a healthcare exposure?

- Presumptive:** Patient had 10 or more days of continuous stay at a healthcare facility during the 14 days before onset of symptoms
- Possible:** Patient had exposure to a healthcare facility for a portion of the entire 14 days prior to onset
- No:** No exposure to a healthcare facility in the 14 days prior to onset
- Unknown**

20. In the 14 days before onset, did the patient visit or stay in an assisted living facility or senior living facility? Assisted/senior living facilities do not provide skilled nursing or medical care.

Yes No Unknown

If yes, please complete the following information:

Type of setting/facility:	Assisted living facility	Senior living facility	Unknown
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**Name of assisted/senior living facility 1:** \_\_\_\_\_

Type of exposure:	Resident	Visitor or volunteer	Employee	Other, specify: _____	Unknown
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Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of arrival: \_\_\_\_\_ Date of departure: \_\_\_\_\_ Did the assisted/senior living facility have in place a water management program to reduce the risk of *Legionella* growth and spread? Yes No Unknown

Comments about assisted or senior living facility: \_\_\_\_\_

21. Was this case associated with an assisted or senior living facility?

- Presumptive:** Patient had 10 or more days of continuous stay at an assisted/senior living facility during the 14 days before onset of symptoms
- Possible:** Patient had exposure to an assisted/senior living facility for a portion of the entire 14 days prior to onset
- No:** No exposure to an assisted/senior living facility in the 14 days prior to onset
- Unknown**

22. Was this case associated with a known outbreak or possible cluster?

- Yes
- No
- Unknown

If yes, specify name of facility, city, and state of outbreak:

**Name of facility:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

23. If this case was associated with an outbreak reported to NORS (National Outbreak Reporting System), what is the CDC-assigned NORS outbreak ID?

\_\_\_\_\_

24. Laboratory diagnostic tests:

Tests	Date collected (mm/dd/yyyy)	Specimen type	Results
Urinary antigen test (UAT)	_____	Urine	Positive Indeterminant Negative Not performed Unknown
Culture	_____	Lower respiratory secretions (e.g., sputum, BAL) Other, specify: _____	Positive Indeterminant Negative Not performed Unknown
Nucleic acid assay (e.g., PCR)	_____	Lower respiratory secretions (e.g., sputum, BAL) Other, specify: _____	Positive Indeterminant Negative Not performed Unknown
Direct fluorescent antibody (DFA) or immunohistochemistry (IHC)	_____	Lower respiratory secretions (e.g., sputum, BAL) Other, specify: _____	Positive Indeterminant Negative Not performed Unknown

25. If culture, nucleic acid assay (e.g., PCR), or DFA/IHC were performed, specify species and/or serogroup identified:

Species: \_\_\_\_\_ Serogroup: \_\_\_\_\_

26. Serologic tests:

Antibody titer test	Date collected (mm/dd/yyyy)	Quantitative titer value	Results
Antibody titer to <i>Legionella pneumophila</i> serogroup 1	Acute: _____  Convalescent: _____	Acute: _____  Convalescent: _____	Positive (4x or greater rise in titer) Indeterminant Negative Not performed Unknown
Antibody titer OTHER THAN <i>Legionella pneumophila</i> serogroup 1 or to multiple species or serogroups of <i>Legionella</i> using pooled antigen	Acute: _____  Convalescent: _____	Acute: _____  Convalescent: _____	Positive (4x or greater rise in titer) Indeterminant Negative Not performed Unknown

27. Was a specimen(s) sent to CDC for testing?

- Yes
- No
- Unknown

Date specimen(s) sent to CDC for testing: \_\_\_\_\_

28. Case status:

- Confirmed
- Suspect
- Probable
- Not a case

If probable, indicate epidemiologic link: \_\_\_\_\_

29. In the 14 days before onset, was the patient exposed to any of the following? *If yes, indicate location and dates.*

Potential exposure(s)	Yes/No/Unknown			Location (facility name, city, state)	Date(s)
Shower away from home	Yes	No	Unknown		
In or near a Hot tub	Yes	No	Unknown		
Near a decorative water fountain or water feature	Yes	No	Unknown		
Near a mister	Yes	No	Unknown		
Near a sprinkler	Yes	No	Unknown		
Recreational water park	Yes	No	Unknown		
Near some other water aerosolizing device:	Yes	No	Unknown		
Attend a convention, reception, conference, or other public gathering	Yes	No	Unknown		
Visit or live in a congregate living facility (e.g., correctional facilities, shelters, dormitories, etc.)	Yes	No	Unknown		
Visit an area with large buildings (e.g., shopping centers, high-rise complexes, etc.) that may have a cooling tower(s)	Yes	No	Unknown		
Construction/remodeling near home or place visited	Yes	No	Unknown		
Work with water device/system maintenance (e.g., cooling towers, plumbing, hot tub)	Yes	No	Unknown		
Work in water-related leisure (e.g., hotels, cruise ships, water parks)	Yes	No	Unknown		
Industrial/manufacturing plant with a water spray cooling system or processes involving spraying water	Yes	No	Unknown		
Commercial or long haul truck driving	Yes	No	Unknown		
Work in commercial kitchen	Yes	No	Unknown		
Work in custodial services (e.g., housekeeping, janitorial)	Yes	No	Unknown		
Work in construction (e.g., spraying water, demolition, refurbishing)	Yes	No	Unknown		
Work at wastewater treatment plant	Yes	No	Unknown		
Work in another occupation involving water exposures:	Yes	No	Unknown		

30. In the 14 days before onset, did the patient use respiratory therapy equipment (e.g., nebulizer, CPAP, BiPAP) for treatment of sleep apnea, COPD, asthma, or any other reason?

Yes      No      Unknown

*\*If yes to respiratory therapy equipment, does this device use a humidifier?*

Yes      No      Unknown

*\*If yes, what type of water is used in the device? (check all that apply)*

Sterile      Bottled      Other  
Distilled      Tap      Unknown

31. In the 14 days before onset, did the patient take a cruise?      Yes                      No                      Unknown

If yes,

Name of cruise line: \_\_\_\_\_ Name of ship: \_\_\_\_\_

Cruise departure city: \_\_\_\_\_ Cruise departure state: \_\_\_\_\_

Cruise departure country: \_\_\_\_\_ Cruise departure date: \_\_\_\_\_

Cruise return city: \_\_\_\_\_ Cruise return state: \_\_\_\_\_

Cruise return country: \_\_\_\_\_ Cruise return date: \_\_\_\_\_ Cabin number: \_\_\_\_\_

Ports of call:

City	State	Country	Date

32. Did the patient have any underlying conditions or prior illnesses?      Yes                      No                      Unknown

If yes, indicate whether the patient has each of the following underlying conditions

Condition	Patient History			Condition	Patient History		
AIDS	Yes	No	Unknown	Kidney disease	Yes	No	Unknown
Alcohol abuse (current/past)	Yes	No	Unknown	Leukemia	Yes	No	Unknown
Asthma	Yes	No	Unknown	Multiple myeloma	Yes	No	Unknown
Blood cancer	Yes	No	Unknown	Multiple sclerosis	Yes	No	Unknown
Bone marrow transplant	Yes	No	Unknown	Myocardial infarction	Yes	No	Unknown
Broken skin	Yes	No	Unknown	Nephrotic syndrome	Yes	No	Unknown
Cancer	Yes	No	Unknown	Neuromuscular disorder	Yes	No	Unknown
Cancer treatment	Yes	No	Unknown	Obesity	Yes	No	Unknown
Cerebrospinal fluid leak	Yes	No	Unknown	Paralysis	Yes	No	Unknown
Cerebrovascular accident	Yes	No	Unknown	Parkinson's disease	Yes	No	Unknown
Chronic respiratory disease	Yes	No	Unknown	Peptic ulcer	Yes	No	Unknown
Chronic hepatitis C	Yes	No	Unknown	Peripheral neuropathy	Yes	No	Unknown
Cirrhosis/liver failure	Yes	No	Unknown	Peripheral vascular disease	Yes	No	Unknown
Cochlear prosthesis	Yes	No	Unknown	Premature birth	Yes	No	Unknown
Complement deficiency disease	Yes	No	Unknown	Renal failure/dialysis	Yes	No	Unknown
Congestive heart failure	Yes	No	Unknown	Seizure disorder	Yes	No	Unknown
Connective tissue disorder	Yes	No	Unknown	Sickle cell trait	Yes	No	Unknown
Coronary arteriosclerosis	Yes	No	Unknown	Smoker – current	Yes	No	Unknown
Corticosteroids	Yes	No	Unknown	Smoker – former	Yes	No	Unknown
Current chronic dialysis	Yes	No	Unknown	Solid organ malignancy	Yes	No	Unknown
Deafness/profound hearing loss	Yes	No	Unknown	Solid organ transplant	Yes	No	Unknown
Dementia	Yes	No	Unknown	Spleen missing	Yes	No	Unknown
Diabetes mellitus	Yes	No	Unknown	Splenectomy/asplenia	Yes	No	Unknown
Emphysema/COPD	Yes	No	Unknown	Systemic lupus erythematosus	Yes	No	Unknown
HIV infection	Yes	No	Unknown	Trouble swallowing (dysphagia)	Yes	No	Unknown
Hodgkin's disease (clinical)	Yes	No	Unknown	Other (specify):	Yes	No	Unknown
Immunoglobulin deficiency	Yes	No	Unknown				
Immunosuppressive therapy	Yes	No	Unknown				
Intravenous drug user	Yes	No	Unknown				
				Unknown	Yes	No	

33. Was the patient or proxy interviewed by public health?

Yes                      No                      Unknown

**Comments:**

Interviewer's name: \_\_\_\_\_

Affiliation: \_\_\_\_\_ Phone: \_\_\_\_\_

State health dept. official who reviewed this report: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

**Local Health Dept. please submit this document to:**

State/DHD/SSS via your communicable disease clerk

**State Health Dept. return completed form to:**

[travellegionella@cdc.gov](mailto:travellegionella@cdc.gov)

Respiratory Diseases Branch, MS H24-6

Office of Infectious Diseases

Center for Disease Control and Prevention and Control

1600 Clifton Rd. NE, Atlanta, GA 30329

## Appendix (Additional Facilities)

(Additional accommodations – continued from page 1)

**Name of accommodation 3:** \_\_\_\_\_

Street address: \_\_\_\_\_ Room number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Country: \_\_\_\_\_ Date of arrival: \_\_\_\_\_ Date of departure: \_\_\_\_\_

**Comments about travel:**

\_\_\_\_\_

**Name of accommodation 4:** \_\_\_\_\_

Street address: \_\_\_\_\_ Room number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Country: \_\_\_\_\_ Date of arrival: \_\_\_\_\_ Date of departure: \_\_\_\_\_

**Comments about travel:**

\_\_\_\_\_

(Additional healthcare facilities – continued from page 2)

**Name of healthcare facility 3:** \_\_\_\_\_

Type of healthcare setting/facility: Hospital _____ Long-term care _____ Clinic _____ Unknown _____ Other, specify: _____	Type of exposure: Inpatient _____ Outpatient _____ Visitor or volunteer _____ Employee _____ Unknown _____ Other, specify: _____	Is this facility also a transplant center? Yes _____ No _____ Unknown _____
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Street address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Date of arrival: \_\_\_\_\_ Date of departure: \_\_\_\_\_

Did the healthcare facility have in place a water management program to reduce the risk of *Legionella* growth and spread? Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown \_\_\_\_\_

**Comments about healthcare setting:**

\_\_\_\_\_

(Additional assisted/senior living facilities – continued from page 2)

If yes, what type?	Assisted living facility	Senior living facility	Unknown
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**Name of assisted/senior living facility 2:** \_\_\_\_\_

Type of exposure: Resident \_\_\_\_\_ Visitor or volunteer \_\_\_\_\_ Employee \_\_\_\_\_ Other, specify: \_\_\_\_\_ Unknown \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of arrival: \_\_\_\_\_ Date of departure: \_\_\_\_\_

Did the assisted/senior living facility have in place a water management program to reduce the risk of *Legionella* growth and spread? Yes \_\_\_\_\_ No \_\_\_\_\_ Unknown \_\_\_\_\_

**Comments about assisted or senior living facility:**

\_\_\_\_\_