Legionellosis Report Form

INTERVIEW

EpiTrax # ___________________  Interviewer Name: ____________________________________________

Number of Call Attempts: ___________________  Date of Interview (must enter MM/DD/YYYY): _______

Follow-up Status:  
☐ Interviewed  
☐ Refused Interview  
☐ Lost to Follow-Up*  

Respondent was:  
☐ Self  
☐ Parent  
☐ Spouse  
☐ Other, Specify: ___________________

*At least three attempts at different times of the day should be made before the considered lost to follow-up.

DEMOGRAPHICS

Birth Gender:  
☐ Male  
☐ Female  

Hispanic/Latino Origin:  
☐ Yes  
☐ No  
☐ Unknown  

How would you describe your race?  
☐ White  
☐ Black/African American  
☐ American Indian/Alaska Native  
☐ Asian  
☐ Native Hawaiian/Other Pacific Islander  
☐ Other ______  
☐ Unknown

Date of Birth: ____________  
Age: ____________

CLINICAL

Did you have any symptoms?  
☐ Yes  
☐ No  
☐ Unknown  

If yes, turn to page 2 and record specific symptoms under Investigation.

What date did you start to have symptoms of illness?  
Onset Date: ____________  
Onset Time: ____________

Calculate Legionellosis exposure time frame **12 days** before onset

Do not read to patient; however, use the information to assess exposure.

Exposure period: ____________

Did you recover?  
☐ Yes  
☐ No  
☐ Unknown  

Were you hospitalized?  
☐ Yes  
☐ No  
☐ Unknown

If Yes, Recovery Date: ____________  
If Yes, Hospital Name: __________________________

Time Recovered: ____________

Admit date: ____________  
Discharge Date: ____________
Did you receive medication for this illness?  □ Yes  □ No  □ Unknown

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Date Started</th>
<th>Date Ended</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Clinical Notes:
________________________________________________________________________
________________________________________________________________________

EPIDEMIOLOGICAL

Occupation: ____________________________________________

Imported from:  □ Indigenous  □ Outside U.S.  □ Outside of County  □ Out of State  □ Unknown

INVESTIGATION

A. Clinical Symptoms

Fever?  □ Yes  □ No  □ Unknown  If yes, highest measured temperature (°F) ____

Cough?  □ Yes  □ No  □ Unknown

Fatigue/Malaise/Weakness?  □ Yes  □ No  □ Unknown

Pneumonia (X-ray diagnosed)?  □ Yes  □ No  □ Unknown

Loss of Appetite?  □ Yes  □ No  □ Unknown

Chills?  □ Yes  □ No  □ Unknown

Diagnosis?  □ Legionnaires’ Disease  □ Pontiac Fever  □ Other  □ Unknown
B. Travel Exposure

In the 10 days before illness, did you …

Spend any nights away from home (excluding healthcare settings)?  □ Yes  □ No  □ Unknown

If yes, specify the following:

Location #1
- Accomodation Name: ____________________________________________________________
- Accomodation Room Number: _____________________________________________________
- Accomodation Address: __________________________________________________________
- City, County, State, Zip: _________________________________________________________
- Country: ______________________________________________________________________
- Dates of Stay (Arrival/Departure): _______________________________________________

Location #2
- Accomodation Name: ____________________________________________________________
- Accomodation Room Number: _____________________________________________________
- Accomodation Address: __________________________________________________________
- City, County, State, Zip: _________________________________________________________
- Country: ______________________________________________________________________
- Dates of Stay (Arrival/Departure): _______________________________________________

Location #3
- Accomodation Name: ____________________________________________________________
- Accomodation Room Number: _____________________________________________________
- Accomodation Address: __________________________________________________________
- City, County, State, Zip: _________________________________________________________
- Country: ______________________________________________________________________
- Dates of Stay (Arrival/Departure): _______________________________________________

C. Water Exposure

In the 10 days before illness, did you get in or near a…

• Hot tub, Whirlpool spa, or Jacuzzi?  □ Yes  □ No  □ Unknown
- Location/Date #1: _________________________________________________________________
- Location/Date #2: _________________________________________________________________
- Location/Date #3: _________________________________________________________________
• Swimming Pool? □ Yes □ No □ Unknown
  o Location/Date #1: ________________________________
  o Location/Date #2: ________________________________
  o Location/Date #3: ________________________________

• Decorative fountain or water feature? □ Yes □ No □ Unknown
  o Location/Date #1: ________________________________
  o Location/Date #2: ________________________________
  o Location/Date #3: ________________________________

In the 10 days before onset of symptoms, did you visit a/an…

• Water Park? □ Yes □ No □ Unknown
  o Location/Date #1: ________________________________
  o Location/Date #2: ________________________________
  o Location/Date #3: ________________________________

• Amusement Park? □ Yes □ No □ Unknown
  o Location/Date #1: ________________________________
  o Location/Date #2: ________________________________
  o Location/Date #3: ________________________________

• Grocery Store with a vegetable/fruit mister? □ Yes □ No □ Unknown
  o Location/Date #1: ________________________________
  o Location/Date #2: ________________________________
  o Location/Date #3: ________________________________

In the 10 days before onset of symptoms, did you use a humidifier? □ Yes □ No □ Unknown
  If yes, what type of water is used in the device?
  □ Sterile □ Distilled
  □ Bottled □ Tap
  □ Other □ Unknown
D. Medical Exposure

In the 10 days before illness, did you use for the treatment of sleep apnea, COPD, asthma or any other reason a…

- Nebulizer?
  - Does this device use a humidifier?
    - If yes, what type of water is used?
      - Sterile
      - Distilled
      - Bottled
      - Tap
      - Other
      - Unknown

- CPAP?
  - Does this device use a humidifier?
    - If yes, what type of water is used?
      - Sterile
      - Distilled
      - Bottled
      - Tap
      - Other
      - Unknown

- BiPAP?
  - Does this device use a humidifier?
    - If yes, what type of water is used?
      - Sterile
      - Distilled
      - Bottled
      - Tap
      - Other
      - Unknown

- Any other respiratory equipment?
  - Does this device use a humidifier?
    - If yes, what type of water is used?
      - Sterile
      - Distilled
      - Bottled
      - Tap
      - Other
      - Unknown
In the 10 days before illness, did you visit or stay in any healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?

☐ Yes  ☐ No  ☐ Unknown

If yes, specify the following:

**Location #1**

- Type of Setting:
  - ☐ Hospital
  - ☐ Long Term Care
  - ☐ Clinic
  - ☐ Other, specify: _______________________

- Type of Exposure:
  - ☐ Inpatient
  - ☐ Outpatient
  - ☐ Visitor/Volunteer
  - ☐ Employee

- Name of Facility: ____________________________________________________________

- Is the Facility also a transplant center?  ☐ Yes  ☐ No  ☐ Unknown

- Reason for visit:______________________________________________________________

- City, County, State, Zip: _____________________________________________________

- Country: ______________________________________________________________________

- Dates of visit/admission: ________________  Discharge date: ________________

**Location #2**

- Type of Setting:
  - ☐ Hospital
  - ☐ Long Term Care
  - ☐ Clinic
  - ☐ Other, specify: _______________________

- Type of Exposure:
  - ☐ Inpatient
  - ☐ Outpatient
  - ☐ Visitor/Volunteer
  - ☐ Employee

- Name of Facility: ____________________________________________________________

- Is the Facility also a transplant center?  ☐ Yes  ☐ No  ☐ Unknown

- Reason for visit:______________________________________________________________

- City, County, State, Zip: _____________________________________________________

- Country: ______________________________________________________________________

- Dates of visit/admission: ________________  Discharge date: ________________
**Location #3**

- **Type of Setting:**
  - [ ] Hospital
  - [ ] Long Term Care
  - [ ] Clinic
  - [ ] Other, specify: _______________________

- **Type of Exposure:**
  - [ ] Inpatient
  - [ ] Outpatient
  - [ ] Visitor/Volunteer
  - [ ] Employee

- **Name of Facility:** __________________________________________________________

- **Is the Facility also a transplant center?**
  - [ ] Yes
  - [ ] No
  - [ ] Unknown

- **Reason for visit:**________________________________________________________________

- **City, County, State, Zip:** _________________________________________________________

- **Country:** ______________________________________________________________________

- **Dates of visit/admission:** ___________  Discharge date: _________________

In the 10 days before illness, did you visit or stay in an assisted living facility or senior living facility?

- [ ] Yes
- [ ] No
- [ ] Unknown

If yes, specify the following:

**Location #1**

- **Type of Setting:**
  - [ ] Assisted Living
  - [ ] Senior Living Facility (including retirement homes without skilled nursing or personal care)

- **Type of Exposure:**
  - [ ] Resident
  - [ ] Visitor/Volunteer
  - [ ] Employee

- **Name of Facility:** __________________________________________________________

- **City, County, State, Zip:** _________________________________________________________

- **Country:** ______________________________________________________________________

- **Dates of visit/admission:** ___________  Discharge date: _________________

**Location #2**

- **Type of Setting:**
  - [ ] Assisted Living
  - [ ] Senior Living Facility (including retirement homes without skilled nursing or personal care)

- **Type of Exposure:**
  - [ ] Resident
  - [ ] Visitor/Volunteer
  - [ ] Employee

- **Name of Facility:** __________________________________________________________

- **City, County, State, Zip:** _________________________________________________________

- **Country:** ______________________________________________________________________

- **Dates of visit/admission:** ___________  Discharge date: _________________
Location #3

- **Type of Setting:**
  - Assisted Living
  - Senior Living Facility (including retirement homes without skilled nursing or personal care)

- **Type of Exposure:**
  - Resident
  - Visitor/Volunteer
  - Employee

- **Name of Facility:** ____________________________________________________________

- **City, County, State, Zip:** _________________________________________________________

- **Country:** ______________________________________________________________________

- **Dates of visit/admission:** ________________  Discharge date: ________________

**Was this case associated with a healthcare exposure? (Choose One)**

- **Definitely:** patient was hospitalized or a resident of a long term care facility for the entire 10 days prior to onset of symptoms

- **Possibly:** patient had exposure to a healthcare facility for a portion of the 10 days prior to onset of symptoms

- **No:** no exposure to a healthcare facility in the 10 days prior to onset of symptoms

- **Other:** Specify, __________________________________________________________________

- **Unknown**