



Legionellosis Report Form

INTERVIEW

EpiTrax # _____ Interviewer Name: _____

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

Follow-up Status: Interviewed Respondent was: Self
 Refused Interview Parent
 Lost to Follow-Up* 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 Hispanic/Latino Origin: How would you describe your race?
 Female Yes White
Date of Birth: _____ No Black/African American
Age: _____ Unknown American Indian/Alaska Native
 Asian
 Native Hawaiian/Other Pacific Islander
 Other _____
 Unknown

CLINICAL

Did you have any symptoms? Yes If yes, turn to page 2 and record specific
 No symptoms under Investigation.
 Unknown

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 Were you hospitalized? Yes
 No No
 Unknown Unknown

If Yes, Recovery Date: _____ If Yes, Hospital Name: _____

Time Recovered: _____ Admit date: _____ Discharge Date: _____

Did the patient die?

Yes No Unknown

If Yes, Date of Death: _____

Is the patient pregnant?

Yes No Unknown

If Yes, Expected Delivery Date: _____

Did you receive medication for this illness?

Yes No Unknown

Medication Name	Date Started	Date Ended

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
 - Location/Date #1: _____
 - Location/Date #2: _____
 - Location/Date #3: _____

- Decorative fountain or water feature? Yes No Unknown
 - Location/Date #1: _____
 - Location/Date #2: _____
 - Location/Date #3: _____

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

- Water Park? Yes No Unknown
 - Location/Date #1: _____
 - Location/Date #2: _____
 - Location/Date #3: _____

- Amusement Park? Yes No Unknown
 - Location/Date #1: _____
 - Location/Date #2: _____
 - Location/Date #3: _____

- Grocery Store with a vegetable/fruit mister? Yes No Unknown
 - Location/Date #1: _____
 - Location/Date #2: _____
 - 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? Yes No Unknown
 - Does this device use a humidifier? Yes No Unknown
 - If yes, what type of water is used? Sterile Distilled
 - Bottled Tap
 - Other Unknown

- CPAP? Yes No Unknown
 - Does this device use a humidifier? Yes No Unknown
 - If yes, what type of water is used? Sterile Distilled
 - Bottled Tap
 - Other Unknown

- BiPAP? Yes No Unknown
 - Does this device use a humidifier? Yes No Unknown
 - If yes, what type of water is used? Sterile Distilled
 - Bottled Tap
 - Other Unknown

- Any other respiratory equipment? Yes No Unknown
 - Does this device use a humidifier? Yes No Unknown
 - 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**