

Patient's Name: \_\_\_\_\_ (Last, First, M.I.) \_\_\_\_\_ (Telephone No.) \_\_\_\_\_ Hospital: \_\_\_\_\_  
 Address: \_\_\_\_\_ (Number, Street, Apt. No., City, State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_ Patient Chart No.: \_\_\_\_\_

-- Patient identifier information is not transmitted to CDC --

U.S. DEPARTMENT OF HEALTH  
& HUMAN SERVICES  
Centers for Disease Control  
and Prevention (CDC)  
Atlanta, Georgia 30333

## LEGIONELLOSIS CASE REPORT

(DISEASE CAUSED BY ANY LEGIONELLA SPECIES)



Form Approved OMB No. 0920-0009

## - PATIENT INFORMATION -

|                                            |                             |                                                                                                                                                                                           |                                                                                                                                                                                                                                                                  |                                                                                                                                                   |                         |
|--------------------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 1. State Health Dept. Case No.<br>_____    | 2. Reporting State:<br>____ | 3. (CDC Use Only)<br>Case No. _____                                                                                                                                                       | 4. County of Residence<br>_____                                                                                                                                                                                                                                  | 5. State of Residence<br>____                                                                                                                     | 6. Occupation:<br>_____ |
| 7a. Date of Birth:<br>Mo. Day Year<br>____ | 7b. Age:<br>____            | 8. Sex:<br>1 <input type="checkbox"/> Days<br>2 <input type="checkbox"/> Mos.<br>3 <input type="checkbox"/> Years<br>1 <input type="checkbox"/> Male<br>2 <input type="checkbox"/> Female | 9. Race:<br>1 <input type="checkbox"/> White 3 <input type="checkbox"/> American Indian/<br>Alaskan Native 8 <input type="checkbox"/> Other<br>2 <input type="checkbox"/> Black 4 <input type="checkbox"/> Asian/Pacific Islander 9 <input type="checkbox"/> Unk | 10. Ethnic Origin:<br>1 <input type="checkbox"/> Hispanic/Latino 9 <input type="checkbox"/> Unk<br>2 <input type="checkbox"/> Not Hispanic/Latino |                         |

## 11. Possible sources of exposure:

IN THE TWO WEEKS BEFORE ONSET, DID PATIENT:

a) Travel or stay overnight somewhere other than usual residence? CITY LODGING

1 ☐ Yes 2 ☐ No 9 ☐ UnkIf Yes, give cities and  
lodging where available:

\* For suspected travel related cases, please contact CDC or pertinent state health departments immediately.

b) Have dental work?

1 ☐ Yes 2 ☐ No 9 ☐ UnkIf Yes, name of  
dental office: \_\_\_\_\_

c) Visit a hospital as an outpatient?

1 ☐ Yes 2 ☐ No 9 ☐ Unk

If Yes, name of hospital: \_\_\_\_\_

d) Work in a hospital?

1 ☐ Yes 2 ☐ No 9 ☐ Unk

If Yes, name of hospital: \_\_\_\_\_

## 12. Was case hospital related (nosocomial)?

2 ☐ Not nosocomial: No inpatient or outpatient hospital  
visits in the 10 days prior to onset of symptoms.3 ☐ Possibly nosocomial: Patient hospitalized  
2 - 9 days before onset of legionella infection.9 ☐ Unk1 ☐ Definitely nosocomial: Patient hospitalized continuously  
for ≥ 10 days before onset of legionella infection.8 ☐ Other (Specify) \_\_\_\_\_

## 13. Was this patient's legionella infection: (check one)

1 ☐ Associated with outbreak (Specify location): \_\_\_\_\_2 ☐ Sporadic case 9 ☐ Unk

## - CLINICAL ILLNESS -

## 14. Diagnosis: (check one)

1 ☐ Legionnaires' Disease (Pneumonia, X-ray diagnosed)8 ☐ Other (Specify) \_\_\_\_\_2 ☐ Pontiac fever (fever, myalgia without pneumonia)9 ☐ Unk15. Date of symptom onset  
of LegionellosisMo. Day Year  
\_\_\_\_16. Was patient hospitalized  
for Legionellosis?1 ☐ Yes 2 ☐ No 9 ☐ UnkHospital  
name: \_\_\_\_\_Hospital  
address: \_\_\_\_\_

## 17. Outcome of illness:

1 ☐ Survived 9 ☐ Unk2 ☐ Died

## - CASE DEFINITION -

**Confirmed case has a compatible clinical history and meets at least one of the following criteria:**

- 1) isolation of *Legionella* species from lung tissue, respiratory secretions, pleural fluid, blood or other sterile site
- 2) demonstration of *L. pneumophila*, serogroup 1, in lung tissue, respiratory secretions, or pleural fluid by direct fluorescent antibody testing
- 3) fourfold or greater rise in immunofluorescent antibody titer to *L. pneumophila*, serogroup 1, to 128 or greater
- 4) detection of *L. pneumophila* serogroup 1 antigen in urine

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 DHHS Reports Clearance Officer, Paperwork Reduction Project 0920-0009; Rm 531 H, H.H. Humphrey Bldg., 200 Independence Ave., SW, Washington, DC 20201. While your response is voluntary your cooperation is necessary for the understanding and control of this disease.

– METHOD OF DIAGNOSIS –

PLEASE CHECK ALL METHODS OF DIAGNOSIS WHICH APPLY

1 ☐ **Culture Positive: If Yes,**  
 Date: Mo. Day Year Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions 3 ☐ pleural fluid 4 ☐ blood 8 ☐ Other: (Specify) \_\_\_\_\_  
 Species: \_\_\_\_\_ Serogroup: \_\_\_\_\_

2 ☐ **DFA Positive: If Yes,**  
 Date: Mo. Day Year Site: 1 ☐ lung biopsy 2 ☐ respiratory secretions 3 ☐ pleural fluid 4 ☐ blood 8 ☐ Other: (Specify) \_\_\_\_\_  
 Species: \_\_\_\_\_ Serogroup: \_\_\_\_\_

3 ☐ **Fourfold rise in antibody titer: If Yes,** Date: Mo. Day Year List Species and Serogroup in assay used:  
 Initial (acute) titer 1: \_\_\_\_\_ Species: \_\_\_\_\_ Serogroup: \_\_\_\_\_  
 Convalescent titer 1: \_\_\_\_\_ Species: \_\_\_\_\_ Serogroup: \_\_\_\_\_

4 ☐ **Urine Antigen Positive: If Yes,**  
 Date: Mo. Day Year

– INTERVIEWER IDENTIFICATION –

Interviewer's Name: \_\_\_\_\_ Affiliation: \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_ Date of Interview: Mo. Day Year

– CDC USE ONLY –

**Return completed form to:**

Respiratory Diseases Branch, Mailstop C23  
 National Center for Infectious Diseases  
 Centers for Disease Control and Prevention  
 1600 Clifton Rd. NE  
 Atlanta, GA 30333

Check the appropriate answer: Serogroup: \_\_\_\_\_  
 1 ☐ *L. pneumophila* 6 ☐ *L. feeleii*  
 2 ☐ *L. bozemanii* 7 ☐ *L. longbeachae*  
 3 ☐ *L. dumoffii* 8 ☐ Mixed: (specify) \_\_\_\_\_  
 4 ☐ *L. gormanii* 88 ☐ Other: (specify) \_\_\_\_\_  
 5 ☐ *L. micdadei* 99 ☐ Unk

– COMMENTS –