

LEGIONELLOSIS INVESTIGATION FORM

PATIENT

Information As of Date: ___/___/_____

Name of person being interviewed: _____

Relationship of Patient: _____

Preferred Language: English French German Korean Spanish

If patient <18 years old, provide parent/proxy's name: _____

Has the patient been notified by the reporter of this diagnosis or lab result? No Unknown Yes

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ___/___/_____ Age: _____ years months Current Sex: Female Male Unknown

Is the patient deceased? No Unknown Yes Date of Death: ___/___/_____

Marital Status: Annulled Common Law Divorced Domestic partner Interlocutory Legally Separated Living Together Married
 Polygamous Refused to answer Separated Single, never married Unknown Unmarried Unreported
 Widowed Other

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (____) - ____ - _____ Cell Phone: (____) - ____ - _____ Work Phone: (____) - ____ - _____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

Country of Birth: _____

Primary Occupation: _____

Industry: _____

Name and Location of Employer: _____

INVESTIGATION INFORMATION

Investigation Start Date: ___/___/_____ Investigation Status: Open Closed Investigator: _____

Date Assigned to Investigation: ___/___/_____

Were you able to interview the patient or representative? Yes No

Date of Initial Interview Attempt: ___/___/_____

Date of Completed Interview: ___/___/_____

Date ADPH investigator provided patient, or patient representative with control measures: ___/___/_____

If control measures were not provided, explain:

REPORTING INFORMATION

Date of Report: ___/___/_____ Reporting Source: _____

Reporting Source Name: _____

CLINICAL

Physician's Name: _____ Phone Number: (____) - ____ - ____ Ext. _____

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name: _____

Admission Date: ____/____/____ Discharge Date: ____/____/____ Duration of Stay _____ day(s)

Was there a second hospitalization? No Unknown Yes

Second Admission Date: ____/____/____

EPIDEMIOLOGICDoes this patient know of any similarly ill persons? No Unknown YesIs this case part of an outbreak? No Unknown Yes If yes, outbreak name: _____

Binational Reporting Criteria:

- Exposure to suspected product from Canada or Mexico
- Has case contacts in or from Mexico or Canada
- Other situations that may require binational notification or coordination of response
- Potentially exposed by a resident of Mexico or Canada
- Potentially exposed while in Mexico or Canada
- Resident of Canada or Mexico

Transmission Mode: Airborne Bloodborne Dermal Foodborne Indeterminate Mechanical Nosocomial Sexually Transmitted
Transplacental transmission Vectorborne Waterborne Zoonotic Unknown

MMWR Week: _____ MMWR Year: _____

Case Status: Confirmed Probable Suspect Unknown Not a Case

(For State-level Use Only): ARWFTI: _____

(For State-level Use Only): CSV: _____

NOSOCOMIAL RELATED**DEFINITELY:** Patient was hospitalized or a resident of a long term care facility for the entire 10 days prior to onset; **POSSIBLY:** Patient had an exposure to a healthcare facility for a portion of the 10 days prior to onset; **NO:** No exposure to a healthcare facility in the 10 days prior to onsetWas this case associated with a healthcare exposure?: Definitely Possibly No Other Unknown

If selection is 'Other' specify: _____

DISEASE ACQUISITIONWhere was the disease acquired?: Imported, But Not Able to Determine Source State and/or County In State, Out of Jurisdiction
 Indigenous International Out of State Unknown

If the selection is 'Imported' or 'International' provide:

Imported Country: _____

Imported State: _____

Imported County: _____

Imported City: _____

If the selection is 'Out of State' provide:

Imported State: _____

Imported County: _____

Imported City: _____

JCDH ADMINISTRATIVE SECTIONDate Due: ____/____/____ Investigation ready for supervisor review: Reviewed (Complete) Reviewed (Incomplete)Date investigation ready for supervisor review: ____/____/____ Reviewed (Not a case) Yes

Review comments (completed by supervisor): _____

EXPOSURE—OVERNIGHT STAY (10 DAYS PRIOR TO ONSET)

Did the patient spend any nights away from home (excluding healthcare settings)?: No Unknown Yes

If yes, Accommodation Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Country: _____

Room Number: _____

Arrival Date: ___/___/_____

Departure Date: ___/___/_____

***ADDITIONAL LOCATIONS CAN BE NOTED ON PAGE 6/7**

EXPOSURE—HEALTHCARE FACILITY

Did the patient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?: No Unknown Yes

Type of healthcare setting/facility: Clinic Hospital Long Term Care Other (specify) _____

Type of exposure: Employee Inpatient Outpatient Resident Visitor or Volunteer
Other (specify) _____

Name of Facility: _____

Is this facility also a transplant center?: No Unknown Yes

Reason for visit:

City: _____

State: _____

Date of Visit/Admission (start date): ___/___/_____

Date of Visit/Admission (end date): ___/___/_____

***ADDITIONAL HEALTHCARE FACILITIES CAN BE NOTED ON PAGE 7**

EXPOSURE—ASSISTED/SENIOR LIVING FACILITY

Did the patient visit or stay in an assisted living facility or senior living facility?: No Unknown Yes

Type of facility: Assisted Living Senior Living Other (specify): _____

Type of exposure: Employee Inpatient Outpatient Resident Visitor or Volunteer
Other (specify) _____

Name of facility: _____

City: _____

State: _____

Date of Visit/Admission (start date): ___/___/_____

Date of Visit/Admission (end date): ___/___/_____

***ADDITIONAL ASSISTED/SENIOR LIVING FACILITIES CAN BE NOTED ON PAGE 7/8**

OTHER POTENTIAL EXPOSURES

Did the patient have dental work or oral surgery?: No Unknown Yes

If yes, specify the location of the dental office: _____

Did the patient get in or spend time near a whirlpool spa (i.e. hot tub)?: No Unknown Yes

If yes, describe where: _____

If yes, list dates: _____

Did the patient use a nebulizer, CPAP, BiPAP, or any other respiratory therapy equipment?: No Unknown Yes

If yes, does this device use a humidifier?: No Unknown Yes

If yes, what type of water is used in the device (select all that apply): Bottled Distilled Sterile Tap Unknown Other

If selection is 'Other' specify: _____

Did the patient have contact with a decorative fountain?: No Unknown Yes

If yes, describe where: _____

If yes, list dates: _____

Did the patient have exposure to any industrial cooling towers, showers, or air conditioners?: No Unknown Yes

If yes, describe where: _____

If yes, list dates: _____

Did the patient have an excavation or construction site within eyesight of home or work?: No Unknown Yes

If yes, describe where: _____

If yes, list dates: _____

Did the patient attend a conference or convention? No Unknown Yes

If yes, describe where: _____

If yes, list dates: _____

RISK FACTORS

Did the patient have any of the following risk factors?:

Tobacco Smoking: No Unknown Yes

If yes, packs/items per day: _____

How long (years): _____

Diabetes: No Unknown Yes

If Diabetes Mellitus, please specify whether on insulin: No Unknown Yes

Chronic Obstructive Pulmonary Disease (COPD), asthma, or emphysema: No Unknown Yes

Immunosuppressive therapy: No Unknown Yes

Renal failure: No Unknown Yes

History of cancer: No Unknown Yes

Hepatic failure: No Unknown Yes

Immunodeficiency Disorder: No Unknown Yes

CLINICAL & LABORATORY INFORMATION

Was lab testing done? No Unknown Yes

If yes, performing lab type: CDC Lab Commercial Lab Public Health Lab

Diagnostic Lab Test Findings: > = 4 fold rise Equivocal Negative Positive Test not done Unknown Other, specify _____

Serogroup: _____

Species: _____

OTHER CLINICAL INFORMATION

Was the patient treated with antibiotics after onset of this illness?: No Unknown Yes

If yes, what type of antibiotic was used?: _____

Prescription Start Date: ___/___/_____

Prescription End Date: ___/___/_____

Total number of days the antibiotic was taken, if known: _____

***CONTINUATION OF ANTIBIOTICS USED**

Second type of antibiotic used: _____

Prescription Start Date: ___/___/_____

Prescription End Date: ___/___/_____

Total number of days the antibiotic was taken, if known: _____

Third type of antibiotic used: _____

Prescription Start Date: ___/___/_____

Prescription End Date: ___/___/_____

Total number of days the antibiotic was taken, if known: _____

Fourth type of antibiotic used: _____

Prescription Start Date: ___/___/_____

Prescription End Date: ___/___/_____

Total number of days the antibiotic was taken, if known: _____

Fifth type of antibiotic used: _____

Prescription Start Date: ___/___/_____

Prescription End Date: ___/___/_____

Total number of days the antibiotic was taken, if known: _____

Sixth type of antibiotic used: _____

Prescription Start Date: ___/___/_____

Prescription End Date: ___/___/_____

Total number of days the antibiotic was taken, if known: _____

Seventh type of antibiotic used: _____

Prescription Start Date: ___/___/_____

Prescription End Date: ___/___/_____

Total number of days the antibiotic was taken, if known: _____

***EXPOSURE—OVERNIGHT STAY (10 DAYS PRIOR TO ONSET)**

2. Accommodation Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Country: _____

Room Number: _____

Arrival Date: ___/___/_____

Departure Date: ___/___/_____

3. Accommodation Name: _____
 Address: _____
 City: _____
 State: _____
 Zip Code: _____
 Country: _____
 Room Number: _____
 Arrival Date: ___/___/_____
 Departure Date: ___/___/_____

***EXPOSURE—HEALTHCARE FACILITY**

2. Type of healthcare setting/facility: Clinic Hospital Long Term Care Other (specify) _____
 Type of exposure: Employee Inpatient Outpatient Resident Visitor or Volunteer
Other (specify) _____
 Name of Facility: _____
 Is this facility also a transplant center?: No Unknown Yes
 Reason for visit: _____
 City: _____
 State: _____
 Date of Visit/Admission (start date): ___/___/_____
 Date of Visit/Admission (end date): ___/___/_____
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 State: _____
 Date of Visit/Admission (start date): ___/___/_____
 Date of Visit/Admission (end date): ___/___/_____

***EXPOSURE—ASSISTED/SENIOR LIVING FACILITY**

2. Type of facility: Assisted Living Senior Living Other (specify): _____
 Type of exposure: Employee Inpatient Outpatient Resident Visitor or Volunteer
Other (specify) _____
 Name of facility: _____
 City: _____
 State: _____
 Date of Visit/Admission (start date): ___/___/_____
 Date of Visit/Admission (end date): ___/___/_____
 3. Type of facility: Assisted Living Senior Living Other (specify): _____
 Type of exposure: Employee Inpatient Outpatient Resident Visitor or Volunteer
Other (specify) _____

Name of facility: _____

City: _____

State: _____

Date of Visit/Admission (start date): ___ / ___ / _____

Date of Visit/Admission (end date): ___ / ___ / _____