

Patient's Name: (Last, First, MI) Phone No.:( )
Address: (Number, Street, Apt. No.) Patient Chart No.:
(City, State) (Zip Code) Hospital:

- Patient identifier information is not transmitted to CDC -

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION ATLANTA, GA 30333

2015 LEGIONELLOSIS ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT FORM A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK



- SHADED AREAS FOR OFFICE USE ONLY -

1. STATE: (Residence of Patient) 2. COUNTY: (Residence of Patient) 3. STATE I.D.: 4a. HOSPITAL/LAB I.D. WHERE FIRST CULTURE IDENTIFIED OR FIRST POSITIVE TEST: 4b. HOSPITAL I.D. WHERE PATIENT TREATED:

5. STATE HEALTH DEPT. CASE NO. (From CDC Legionellosis case report form for passive surveillance): 6. DATE OF SYMPTOM ONSET OF LEGIONELLOSIS: (note this is NOT date of admission) 7a. WAS PATIENT HOSPITALIZED? If YES, date of admission: Date of discharge:

7b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization? 7c. Did the patient require mechanical ventilation? 8a. Excluding the current hospitalization, was the patient hospitalized at any time in the 10 days prior to illness onset? 8b. If YES, hospital I.D.:

9a. Where was the patient a resident in the 10 days prior to illness onset? (Check all that apply) 9b. If resident of a facility, what was the name of the facility? 10a. Was patient transferred from another hospital? 10b. If YES, hospital I.D.:

11. DATE OF BIRTH: 12a. AGE: (at time of onset) 12b. Is age in day/mo/yr? 13. SEX: 14a. ETHNIC ORIGIN: 14b. RACE: (Check all that apply)

15a. WEIGHT: 15b. HEIGHT: 15c. BMI: 16. TYPE OF INSURANCE: (Check all that apply)

17. OUTCOME: 18. If patient died, was the initial culture or first positive test obtained from autopsy?

19. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF ADMISSION? 20. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA?:

21. Did this patient have a positive flu test 10 days prior to or following a positive Legionella culture? 22. Discharge diagnosis (check all that apply): Public reporting burden of this collection of information is estimated to average 10 minutes per response...

23. UNDERLYING CAUSES OR PRIOR ILLNESSES: (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1  None 1  Unknown

- |   |  |  |  |
|---|--|--|--|
| 1 <input type="checkbox"/> AIDS or CD4 count <200                             | 1 <input type="checkbox"/> Diabetes Mellitus   | 1 <input type="checkbox"/> Leukemia                | 1 <input type="checkbox"/> Premature Birth (specify gestational age at birth) <input type="checkbox"/> (wks) |
| 1 <input type="checkbox"/> Alcohol Abuse, Current                             | 1 <input type="checkbox"/> Dysphagia   | 1 <input type="checkbox"/> Multiple Myeloma        | 1 <input type="checkbox"/> Seizure/Seizure Disorder  |
| 1 <input type="checkbox"/> Alcohol Abuse, Past                                | 1 <input type="checkbox"/> Emphysema/COPD  | 1 <input type="checkbox"/> Multiple Sclerosis      | 1 <input type="checkbox"/> Sickle Cell Anemia  |
| 1 <input type="checkbox"/> Asthma   | 1 <input type="checkbox"/> Heart Failure/CHF   | 1 <input type="checkbox"/> Nephrotic Syndrome      | 1 <input type="checkbox"/> Smoker, Current   |
| 1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD | 1 <input type="checkbox"/> HIV Infection   | 1 <input type="checkbox"/> Neuromuscular Disorder  | 1 <input type="checkbox"/> Smoker, Former  |
| 1 <input type="checkbox"/> Bone Marrow Transplant (BMT)                       | 1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma                                    | 1 <input type="checkbox"/> Obesity                 | 1 <input type="checkbox"/> Solid Organ Malignancy  |
| 1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke            | 1 <input type="checkbox"/> Immunoglobulin Deficiency                                     | 1 <input type="checkbox"/> Other Drug Use, Current | 1 <input type="checkbox"/> Solid Organ Transplant  |
| 1 <input type="checkbox"/> Chronic Kidney Disease                             | 1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation) | 1 <input type="checkbox"/> Other Drug Use, Past    | 1 <input type="checkbox"/> Splenectomy/Asplenia  |
| 1 <input type="checkbox"/> Current Chronic Dialysis                           | 1 <input type="checkbox"/> IVDU, Current   | 1 <input type="checkbox"/> Parkinson's Disease     | 1 <input type="checkbox"/> Systemic Lupus Erythematosus (SLE)  |
| 1 <input type="checkbox"/> Cirrhosis/Liver Failure                            | 1 <input type="checkbox"/> IVDU, Past  | 1 <input type="checkbox"/> Peripheral Neuropathy   | 1 <input type="checkbox"/> Other (specify) _____   |
| 1 <input type="checkbox"/> Complement Deficiency                              |  | 1 <input type="checkbox"/> Plegias/Paralysis       |  |
| 1 <input type="checkbox"/> Dementia   |  |  |  |

| Legionella Test   | Was this test ordered?  | Date Collected              | Site  | Result  | Species  |
|---|---|-----------------------------|---|---|--|
| 24. Urine Antigen, EIA                                    | 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown                 | ___/___/___                 |   | 1 <input type="checkbox"/> Positive<br>2 <input type="checkbox"/> Negative<br>9 <input type="checkbox"/> Unknown or Indeterminate   |  |
| 25. Culture   | 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown                 | ___/___/___                 | 1 <input type="checkbox"/> Sputum<br>2 <input type="checkbox"/> BAL/bronchial washing<br>3 <input type="checkbox"/> Lung tissue<br>4 <input type="checkbox"/> Pleural fluid<br>5 <input type="checkbox"/> Blood<br>8 <input type="checkbox"/> Other (specify) _____ | 1 <input type="checkbox"/> Positive<br>2 <input type="checkbox"/> Negative<br>9 <input type="checkbox"/> Unknown or Indeterminate   | 1 <input type="checkbox"/> L. pneumophila<br>If yes, list serogroup:<br>1 <input type="checkbox"/> serogroup 1<br>8 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown<br>2 <input type="checkbox"/> L. species (non-pneumophila)<br>8 <input type="checkbox"/> L. species, other (specify) _____<br>9 <input type="checkbox"/> L. species, unknown or not specified |
| 26. Paired Serology, IFA or ELISA                         | Acute<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown        | Acute<br>___/___/___        |   | Acute<br>1 <input type="checkbox"/> Positive<br>If yes, titer: _____<br>2 <input type="checkbox"/> Negative<br>9 <input type="checkbox"/> Unknown or Indeterminate        | Acute<br>Species: _____<br>Serogroup(s): _____   |
|   | Convalescent<br>1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | Convalescent<br>___/___/___ |   | Convalescent<br>1 <input type="checkbox"/> Positive<br>If yes, titer: _____<br>2 <input type="checkbox"/> Negative<br>9 <input type="checkbox"/> Unknown or Indeterminate | Convalescent<br>Species: _____<br>Serogroup(s): _____  |
| 27. PCR (direct specimen only)                            | 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown                 | ___/___/___                 | 1 <input type="checkbox"/> Sputum<br>2 <input type="checkbox"/> BAL/bronchial washing<br>3 <input type="checkbox"/> Lung tissue<br>4 <input type="checkbox"/> Pleural fluid<br>5 <input type="checkbox"/> Blood<br>8 <input type="checkbox"/> Other (specify) _____ | 1 <input type="checkbox"/> Positive<br>2 <input type="checkbox"/> Negative<br>9 <input type="checkbox"/> Unknown or Indeterminate   | 1 <input type="checkbox"/> L. pneumophila<br>2 <input type="checkbox"/> L. species (non-pneumophila)<br>8 <input type="checkbox"/> L. species, other (specify) _____<br>9 <input type="checkbox"/> L. species, unknown or not specified  |
| 28. DFA (direct fluorescence assay, direct specimen only) | 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown                 | ___/___/___                 | 1 <input type="checkbox"/> Sputum<br>2 <input type="checkbox"/> BAL/bronchial washing<br>3 <input type="checkbox"/> Lung tissue<br>4 <input type="checkbox"/> Pleural fluid<br>5 <input type="checkbox"/> Blood<br>8 <input type="checkbox"/> Other (specify) _____ | 1 <input type="checkbox"/> Positive<br>2 <input type="checkbox"/> Negative<br>9 <input type="checkbox"/> Unknown or Indeterminate   | 1 <input type="checkbox"/> L. pneumophila<br>If yes, list serogroup:<br>1 <input type="checkbox"/> serogroup 1<br>8 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown<br>2 <input type="checkbox"/> L. species (non-pneumophila)<br>8 <input type="checkbox"/> L. species, other (specify) _____<br>9 <input type="checkbox"/> L. species, unknown or not specified |
| 29. IHC (immunohistochemistry)                            | 1 <input type="checkbox"/> Yes<br>2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown                 | ___/___/___                 | 1 <input type="checkbox"/> Sputum<br>2 <input type="checkbox"/> BAL/bronchial washing<br>3 <input type="checkbox"/> Lung tissue<br>4 <input type="checkbox"/> Pleural fluid<br>5 <input type="checkbox"/> Blood<br>8 <input type="checkbox"/> Other (specify) _____ | 1 <input type="checkbox"/> Positive<br>2 <input type="checkbox"/> Negative<br>9 <input type="checkbox"/> Unknown or Indeterminate   | 1 <input type="checkbox"/> L. pneumophila<br>If yes, list serogroup:<br>1 <input type="checkbox"/> serogroup 1<br>8 <input type="checkbox"/> Other (specify) _____<br>9 <input type="checkbox"/> Unknown<br>2 <input type="checkbox"/> L. species (non-pneumophila)<br>8 <input type="checkbox"/> L. species, other (specify) _____<br>9 <input type="checkbox"/> L. species, unknown or not specified |

30. COMMENTS: \_\_\_\_\_

- SURVEILLANCE OFFICE USE ONLY -

|  |   |   |   |  |  |                                |
|--|---|---|---|--|--|--------------------------------|
| 31. Was case first identified through audit?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>9 <input type="checkbox"/> Unknown | 32. Was this case also identified through routine passive notifiable disease surveillance?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown | 33. CRF Status:<br>1 <input type="checkbox"/> Complete<br>2 <input type="checkbox"/> Incomplete<br>3 <input type="checkbox"/> Edited & Correct<br>4 <input type="checkbox"/> Chart unavailable after 3 requests | 34. Does this case have recurrent disease?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown<br>If yes, previous (1st) state ID:<br><input type="text"/> | 35. Case status:<br>1 <input type="checkbox"/> Confirmed<br>2 <input type="checkbox"/> Suspect | 36. Date reported to EIP site:<br>Mo. <input type="text"/> Day <input type="text"/><br>Year <input type="text"/> | 37. Initials of S.O.:<br>_____ |
|--|---|---|---|--|--|--------------------------------|

Submitted By: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
 Physician's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_