



LEGIONELLOSIS INVESTIGATION REPORT FORM

Local health departments should fax completed investigation form to regional DSHS office.
Regional DSHS offices should fax completed investigation form to 512-776-7616.

NBS ID: _____	Case status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Not a Case
Patient name: _____ Last First	Reported by: _____
Address: _____	Agency: _____
City: _____ County: _____ Zip: _____	Phone: _____ Report date: _____
Phone 1: _____ Phone 2: _____	Investigated by: _____
Birthdate: _____ Age: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Agency: _____
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native American/Alaskan	Phone: _____
<input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Email: _____
Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Investigation start date: _____
	Date investigation completed: _____

CLINICAL DATA

Symptom onset date: _____ **Illness end date:** _____

Outcome? Survived Died on: _____ Still ill** Unknown

****If still ill, follow up on patient's outcome in 2-3 weeks and update in NBS.**

Hospitalized? Yes[†] No Unknown

Date of admission: _____ Date of discharge: _____

Hospital name: _____

Hospital address: _____

†If hospitalized in more than one facility, please add hospital details in comments section.

Physician: _____ **Phone:** _____

Was the patient diagnosed with clinical or radiographic pneumonia?

Yes No Unknown

Signs and symptoms (Check all that apply): Altered mental status/confusion

Abdominal pain Chest pain Cough Diarrhea

Fever (Max temp: _____) Headache Pneumonia Malaise

Myalgia (muscle pain) Other: _____

Shortness of breath Vomiting

UNDERLYING HEALTH CONDITIONS

Yes (check all that apply) No Unknown

Asthma Cancer, when? _____

Chemotherapy Chronic kidney disease

Corticosteroid therapy Diabetes Heart disease

HIV/AIDS Liver disease

Organ transplant recipient, when? _____

Other chronic lung disease: _____

Other: _____

HEALTH BEHAVIORS	Yes	No	Unk	Quantity per day (packs, drinks)	Duration (years)
Alcohol consumption	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Current smoker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Former smoker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

LABORATORY DATA (If more than one urinary antigen test performed, record second test in "other legionellosis test" section)

Urine antigen test: Date collected: _____ Result: Positive Negative Unknown

Ordering facility: _____ Reporting facility: _____ Date rec'd by public health: _____

Culture: Date collected: _____

Specimen source: Bronchoalveolar lavage (BAL) or bronchial wash Sputum Pleural fluid Lung tissue Other: _____

Result: Positive Negative Pending Unknown If positive, species and serogroup: _____

Ordering facility: _____ Reporting facility: _____ Date rec'd by public health: _____

Antibody test:

1st (acute) antibody titer: _____ Species / serogroup: _____ Date collected: _____

2nd (convalescent) antibody titer: _____ Species / serogroup: _____ Date collected: _____

Ordering facility: _____ Reporting facility: _____ Date rec'd by public health: _____

Other legionellosis test:

Test name: Nucleic acid assay (PCR) Direct fluorescent antibody (DFA) Other: _____

Date collected: _____ Specimen source: Lung biopsy Sputum Pleural fluid Blood Other: _____

Result: Positive Negative Pending Unknown If positive, species _____ serogroup: _____

Ordering facility: _____ Reporting facility: _____ Date rec'd by public health: _____

Who was interviewed to obtain exposure history?

Patient Surrogate; relationship to patient: _____ Neither; reason: _____

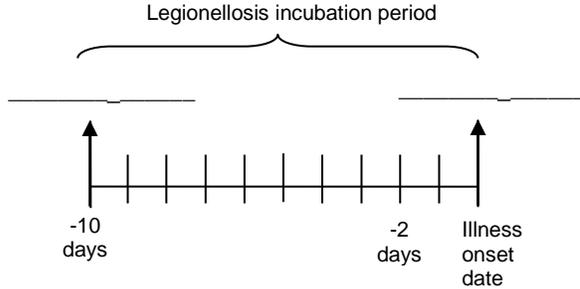
Whenever possible, interview a patient or surrogate to obtain exposure history. If the patient is unable to communicate at the time of investigation, complete the interview with a surrogate but please consider interviewing the patient at a later date. Ask patient/surrogate to refer to a calendar and gather booking info/receipts/itineraries for recent travel and medical stays.

Contact Attempts: Record date(s) and contact method (phone, text, letter):

Date 1: _____ Time: _____	Date 2: _____ Time: _____	Date 3: _____ Time: _____
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Were medical records obtained and abstracted/reviewed for this investigation? Yes No Unknown

INFECTION TIMELINE: Enter onset of illness. Count backward to determine beginning of incubation period for exposure history sections below.



- **Incubation period:** Legionnaires' disease is typically 2–10 days; Pontiac fever is 5–72 hours.
- For all legionellosis cases, please ask about exposures in the **entire 10-day period** prior to illness onset.

TRAVEL HISTORY (OR RESIDENCE IN A TRAVEL ACCOMMODATION)

In the 10 days before onset, did the patient spend any nights away from home (e.g., hotel, motel, cruise ship, train, RV park, resort, hostel, private residence, campground, etc.), excluding healthcare settings, or was the person living in a travel accommodation?

Yes, please complete the table below No Unknown

#	Accommodation name and type [‡]	Address, city, state, zip code, country	Room number	Arrival date	Departure date
1					
2					
3					
4					

If patient was on a cruise ship during the incubation period, complete this investigation form and the CDC Legionellosis Cruise Ship Questionnaire

ADDITIONAL TRAVEL QUESTIONS

If patient reported using a recreational vehicle (RV) or camper in the table above, please ask the following:

Name and location of RV park/campgrounds (if not given above): _____

Campsite/row number: _____ Used drinking water camper/RV hookups? Yes No Unknown

Date(s) when camper/RV water tanks were last flushed: _____

EVENTS

In the 10 days before onset, did the patient attend any conventions, conferences, public gatherings, meetings, festivals, or other events (e.g., wedding, reunion, exhibit, trade show, fair)? Yes, please complete the table below No Unknown

Type of event	Date(s) attended	Name/location and address of event

MEDICAL FACILITY EXPOSURE HISTORY

In the 10 days before onset, did the patient visit, stay, or work at a healthcare setting (e.g., hospital, rehab facility, clinic, dental office)?

Yes, please complete the table below No Unknown

Type of healthcare facility	Type of exposure	Facility name and complete address	Reason for visit	Date(s) of visit / admission	Date of discharge
<input type="checkbox"/> Clinic <input type="checkbox"/> Dental <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____ <input type="checkbox"/> Rehab	<input type="checkbox"/> Employee <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer				
<input type="checkbox"/> Clinic <input type="checkbox"/> Dental <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____ <input type="checkbox"/> Rehab	<input type="checkbox"/> Employee <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer				
<input type="checkbox"/> Clinic <input type="checkbox"/> Dental <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____ <input type="checkbox"/> Rehab	<input type="checkbox"/> Employee <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer				

If yes, was the patient hospitalized or living at the facility for the entire incubation period? Yes^s No Not applicable Unknown

If yes, was the facility a transplant center? Yes No Unknown

In the 10 days before onset, did the patient visit, stay or work at a nursing home, assisted living facility, senior living facility, or similar?

Yes, please complete the table below No Unknown

Type of facility	Type of exposure	Facility name and complete address	Date(s) of visit / admission	Date of discharge
<input type="checkbox"/> Assisted living facility <input type="checkbox"/> Nursing home (with skilled nursing or personal care) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Senior living facility (without skilled nursing or personal care) <input type="checkbox"/> Skilled nursing facility	<input type="checkbox"/> Employee <input type="checkbox"/> Other: _____ <input type="checkbox"/> Resident <input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer			
<input type="checkbox"/> Assisted living facility <input type="checkbox"/> Nursing home (with skilled nursing or personal care) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Senior living facility (without skilled nursing or personal care) <input type="checkbox"/> Skilled nursing facility	<input type="checkbox"/> Employee <input type="checkbox"/> Other: _____ <input type="checkbox"/> Resident <input type="checkbox"/> Visitor <input type="checkbox"/> Volunteer			

If yes, was the patient living at the facility for the entire incubation period? Yes^s No Not applicable Unknown

CORRECTIONAL FACILITY EXPOSURE HISTORY

In the 10 days before onset, did the patient visit, work, or stay at a correctional facility? Yes No Unknown

If yes, name and address of facility: _____

Type of exposure: Inmate Employee Visitor Other: _____

Date(s) of visit or incarceration: _____ Date(s) of release / transfer: _____

Was the patient living at the facility for the entire 10 days before onset? Yes^s No Not applicable Unknown

§Definitions:

Definite facility-associated case: Case spent entire incubation period in the facility

Possible facility-associated case: Case spent a portion of the incubation period in the facility

Outbreak^{||} (one of the following):

- One definitely healthcare-associated case, **OR** at least 2 possibly healthcare-associated cases within 1 year associated with the same healthcare facility
- At least 2 cases associated with the same non-healthcare facility (e.g., hotel, gym, etc.) or other common location (e.g., amusement park) within 1 year

^{||}Note: A thorough investigation is important to exclude other plausible sources of infection (i.e., those not associated with the facility/location).

For outbreak investigation and other instructions, see EAIDB Investigation Guidelines: <http://www.dshs.state.tx.us/IDCU/investigation/Investigation-Guidance/>

OTHER EXPOSURE HISTORY QUESTIONS

In the 10 days before onset, did the patient have exposure (e.g., getting in, sitting/being near, or walking by, even briefly) to any of the following potential sources of misty/aerosolized water, while traveling, hospitalized, or in the case's home city?

Please complete the table below:

Exposure type <i>Includes getting in, sitting/being near, or walking by a functioning/working device</i>	Yes	No	Unknown	Location(s)	Date(s)	Description of exposure and duration (e.g., sat near for 1 hour)
Car Wash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Centralized cooling tower/ HVAC systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Decorative fountain, waterwall, or water display	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Home humidifier or mister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hot springs, mineral baths, or geothermal waters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hot tub or whirlpool spa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Jetted bathtub (away from home, filled and drained after each use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Pressure Washer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Recreational misters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Shower (away from home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Steam room or wet sauna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Store misters (e.g., grocery store, gardening)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Swimming or wading pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Therapeutic spa venue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Waterpark, splash pad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

In the 10 days before onset, did the patient use a nebulizer, CPAP, BiPAP or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma or for any other reason? Yes, please fill in details below No Unknown

Type of device: _____ Date(s): _____ Location: _____

Does the device use a humidifier or misty water? Yes No Unknown

Type of water used in the device? Sterile Distilled Bottled Tap (well) Tap (city) Other: _____ None Unknown

Describe how the device is cleaned: _____

In the 10 days before onset, did the patient have any exposures to soil, potting soil, or compost (e.g., gardening, excavation, etc.)?

Yes No Unknown *If yes, provide place, dates, product, description (e.g., "gardening—potting soil purchased from Store A"):*

Location, soil type, activities: _____ What dates: _____

In the 10 days before onset, does the patient recall any general construction, plumbing projects, water main breaks, or water line work at or near a location where the patient lived, was hospitalized, worked, or visited? Yes No Unknown

If yes, provide place, dates, and description (e.g., "new building construction at Hospital A on 1/1/16"):

Location and details: _____ What dates: _____

Location and details: _____ What dates: _____

Location and details: _____ What dates: _____

In the 10 days before onset, did the patient work, attend school, or volunteer? Yes, please complete table below No Unknown

Job/activity description	Employer/facility	Employer/facility address	Date(s) worked, volunteered, etc.	Duration (e.g., 8 hours/day)

Does the patient know of anyone else with similar symptoms or pneumonia? Yes, please complete the table below No Unknown

Name	Age	Onset date	Contact information	Shared Exposures	Legionella testing done?	Legionella test results
		_____			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		_____			<input type="checkbox"/> Yes <input type="checkbox"/> No	

PUBLIC HEALTH ACTIONS TAKEN (please refer to the Prevention and Control Measures section in the Legionellosis chapter of the EAIDB Investigation Guidelines for examples)

ADDITIONAL COMMENTS

Additional Comments on next page

