North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

LEGIONELLOSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 18

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
Fever ☐Y ☐N ☐U
☐Yes, subjective ☐No
☐Yes, measured ☐Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy): ____/____/____
Fatigue or malaise or weakness ☐Y ☐N ☐U
Loss of appetite (anorexia) ☐Y ☐N ☐U
Chills or rigors ☐Y ☐N ☐U
Headache ☐Y ☐N ☐U
Muscle aches / pains (myalgias) ☐Y ☐N ☐U
Cough ☐Y ☐N ☐U
Pneumonia ☐Y ☐N ☐U
Abdominal pain or cramps ☐Y ☐N ☐U
Diarrhea ☐Y ☐N ☐U
Clinical classification
☐Legionnaire's disease (pneumonia or pneumonitis) confirmed by CXR, CT scan ☐Y ☐N ☐U
☐Pontiac fever (fever and myalgias without pneumonia)
☐Unknown

TREATMENT

Did the patient receive an antibiotic as treatment for this illness? ☐Y ☐N ☐U
Specify antibiotic: _____

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State: _____
Hospital contact name: _____
Telephone: (_____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy): ____/____/____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____
Survived? ☐Y ☐N ☐U
Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐U
Date of death (mm/dd/yyyy): _____/_____/_____
Autopsy performed? ☐Y ☐N ☐U
Patient autopsied in NC? ☐Y ☐N ☐U
County of autopsy: _____
Autopsied outside NC, specify where: _____
Source of death information (select all that apply):
☐Death certificate
☐Autopsy report final conclusions
☐Hospital/discharge physician summary
☐Other

PREDISPOSING CONDITIONS

Any immunosuppressive conditions ☐Y ☐N ☐U
Please specify: _____
Diabetes ☐Y ☐N ☐U
Malignancy ☐Y ☐N ☐U
Specify _____
Liver disease ☐Y ☐N ☐U
☐Chronic liver disease or cirrhosis
☐Liver failure
☐Other liver disease(s)
Kidney disease ☐Y ☐N ☐U
☐Chronic renal failure
☐Acute renal failure
☐Other kidney disease(s)
Chronic lung disease ☐Y ☐N ☐U
(if history of smoking, check yes)
Receiving treatment or taking any medications ☐Y ☐N ☐U
☐Chemotherapy
☐Immunosuppressive therapy, including anti-rejection therapy
☐Radiotherapy
☐Systemic steroids/corticosteroids, including steroids taken by mouth or injection
Was medication taken / therapy provided within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition? _____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? ☐Y ☐N
If yes, specify:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ None of the above

Did patient travel during the 2 weeks prior to onset of symptoms? ..... ☐ Y ☐ N ☐ U

List travel dates, destinations, and lodging

From ____/____/____ to ____/____/____

Destination: _____

Lodging: _____

From ____/____/____ to ____/____/____

Destination: _____

Lodging: _____

From ____/____/____ to ____/____/____

Destination: _____

Lodging: _____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ..... ☐ Y ☐ N ☐ U

List persons and contact information:

_____

_____

_____

Additional travel/residency information:

HEALTH CARE FACILITY AND BLOOD & BODILY FLUID EXPOSURE RISKS

During the 10 days prior to onset of symptoms, did the patient have any of the following health care exposures?

☐ **Hospital**

Visit/admit date (mm/dd/yyyy): ____/____/____

Facility name _____

Has patient been discharged? ..... ☐ Y ☐ N ☐ U

Discharge date (mm/dd/yyyy) ____/____/____

Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A

Name of person notified _____

Date notified (mm/dd/yyyy) ____/____/____

☐ **Long term care facility - resident**
(e.g. nursing home, rest home, rehab)

Visit/admit date (mm/dd/yyyy): ____/____/____

Facility name _____

Has patient been discharged? ..... ☐ Y ☐ N ☐ U

Discharge date (mm/dd/yyyy) ____/____/____

Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A

Name of person notified _____

Date notified (mm/dd/yyyy) ____/____/____

☐ **Outpatient facility - patient**
(e.g. urgent care, clinic, physician office)

Visit date (mm/dd/yyyy): ____/____/____

Facility name _____

Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U ☐ N/A

Name of person notified _____

Date notified (mm/dd/yyyy) ____/____/____

☐ **Dental Facility**

Visit/admit date (mm/dd/yyyy): ____/____/____

Facility name _____

Was facility notified regarding ill patient? ..... ☐ Y ☐ N ☐ U

Name of person notified _____

Date notified (mm/dd/yyyy) ____/____/____

WATER EXPOSURE

During the 10 days prior to onset of symptoms, did the patient have exposure to aerosolized water in household, community or health care (medical or dental) settings? ..... ☐ Y ☐ N ☐ U

If yes, check all that apply:
- ☐ Misters near swimming pool or wading pool
- ☐ Whirlpool/spa pool
- ☐ Hot tub
- ☐ Fountain
- ☐ Cooling tower
- ☐ Evaporative condenser
- ☐ Humidifier
- ☐ Nebulizer
- ☐ Respiratory therapy
- ☐ Artificial ventilation/respirator
- ☐ Grocery store mister
- ☐ Dental water lines
- ☐ Other

Notes:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ..... ☐ Y ☐ N ☐ U

If yes, specify:

Does patient work in a hospital? ..... ☐ Y ☐ N ☐ U

If yes, name of hospital:

_____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ..... ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? ..... ☐ Y ☐ N ☐ U

Who was interviewed?

Were health care providers consulted? ..... ☐ Y ☐ N ☐ U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

OUTDOOR EXPOSURE

During the 10 days prior to onset of symptoms, did the patient participate in any of the following outdoor activities? ..... ☐ Y ☐ N ☐ U

- ☐ Gardening
- ☐ Landscaping
- ☐ Exposure to natural soil or commercial peat or potting soil

If yes, specify and give details:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County _____

☐ Outside NC, but within US

City _____

State _____

County _____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ..... ☐ Y ☐ N

Notes:

Legionellosis *(Legionella pneumophila)*

2005 CDC Case Definition

Clinical description

Legionellosis is associated with two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac Fever, a milder illness without pneumonia.

Laboratory criteria for diagnosis:

Suspect:

- By seroconversion: fourfold or greater rise in antibody titer to specific species or serogroups of *Legionella* other than *L. pneumophila* serogroup 1 *(*e.g., *L. micdadei*, *L. pneumophila* serogroup 6).
- By seroconversion: fourfold or greater rise in antibody titer to multiple species of *Legionella* using pooled antigen and validated reagents.
- By the detection of specific *Legionella* antigen or staining of the organism in respiratory secretions, lung tissue, or pleural fluid by direct fluorescent antibody (DFA) staining, immunohistochemstry (IHC), or other similar method, using validated reagents.
- By detection of *Legionella* species by a validated nucleic acid assay.

Confirmed:

- By culture: isolation of any *Legionella* organism from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluid.
- By detection of *Legionella pneumophila* serogroup 1 antigen in urine using validated reagents.
- By seroconversion: fourfold or greater rise in specific serum antibody titer to *Legionella pneumophila* serogroup 1 using validated reagents.

Case classification

Suspect: a clinically compatible case that meets at least one of the presumptive (suspect) laboratory criteria.

- Travel-associated: a case that has a history of spending at least one night away from home, either in the same country of residence or abroad, in the ten days before onset of illness.

Confirmed: a clinically compatible case that meets at least one of the confirmatory laboratory criteria.

- Travel-associated: a case that has a history of spending at least one night away from home, either in the same country of residence or abroad, in the ten days before onset of illness.