

Legionella investigation form

Case ID | _____ |

A. Investigator details

Name of investigator	Team	Phone details	Date of investigation
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B. Reporter

Date of reporting to MOPH			
<input type="checkbox"/> Locally, specify:	Hospital name	Physician name	Contact details
<input type="checkbox"/> International, specify:	Institution	Focal person	Contact details

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C. Patient identity

Name of patient	Date of birth	Age (y)	
	Sex	Nationality	
<input type="checkbox"/> Primary residence	Country	Locality/caza	Phone
<input type="checkbox"/> Second residence	Country	Locality/caza	Phone
<input type="checkbox"/> Occupation	Occupation	Institution	Work address

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D. Clinical findings

Date of onset	
Diagnosis	<input type="checkbox"/> Legionnaires' disease (pneumonia, clinical or X-ray diagnosed) <input type="checkbox"/> Pontiac fever (fever and myalgia without pneumonia) <input type="checkbox"/> Other (endocarditis, wound infection..), specify:
Was the patient admitted?	<input type="checkbox"/> Yes, specify hospital name: <input type="checkbox"/> No <input type="checkbox"/> Unknown
Date of admission	
Has the patient had a recent organ transplant?	<input type="checkbox"/> Yes, specify organ and date: <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was the patient immunosuppressed for any reason?	<input type="checkbox"/> Yes, specify the underlying condition: <input type="checkbox"/> No <input type="checkbox"/> Unknown
Outcome	<input type="checkbox"/> Recovered <input type="checkbox"/> Still ill <input type="checkbox"/> Death (date of death.../.../...) <input type="checkbox"/> Unknown

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E. Risk factors

1) Possible travel related						
<p>► In the 10 DAYS BEFORE onset, did the patient spend any nights away from home (excluding health care settings)</p> <p><input type="checkbox"/> Yes, complete the table below</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>						
Accommodation name	Address	Country	City	Room number	Dates of stay	
					Arrival	Departure
<p>► Did the patient get or spend time near a whirlpool/Spa?</p> <p><input type="checkbox"/> Yes, specify where:</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>						
2) Possible health care related						
<p>► Does the patient visit a health care center for any time in the TWO WEEKS BEFORE the date of onset of symptoms of legionellosis?</p> <p><input type="checkbox"/> Yes, specify the following points</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>						
Health care facility name	Type of visit (in, out-m visitor, staff...)	Date of visit/admission (from, to)	If admission			
			Diagnosis	Respiratory ventilation (CRAP...)	Water used (bottled other...)	
3) Possible community acquired						
<p>► In TWO WEEKS BEFORE onset of symptoms, did the patient use or spend time near a whirlpool/spa?</p> <p><input type="checkbox"/> Yes, specify where:</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>						
<p>► Is the case related to any cluster?</p> <p><input type="checkbox"/> Yes, specify”:</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>						

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E. Laboratory details

Type of specimen	Nb of specimen	Date of collection	Diagnosis test	Result	Laboratory name
<input type="checkbox"/> .Urine			<input type="checkbox"/> Urine antigen EIA		
<input type="checkbox"/> . Respiratory specimens(sputum, BAL, tracheal aspirate, tissue, ...) specify:			<input type="checkbox"/> Culture <input type="checkbox"/> .PCR <input type="checkbox"/> .DFA		
<input type="checkbox"/> .Serum			<input type="checkbox"/> .IFA		
<input type="checkbox"/> .Isolate			<input type="checkbox"/> .Serogroup determination		

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F. Environmental investigations

► Has sampling of water systems been requested?

Yes, specify”:

No

Unknown

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G. Additional information

Please provide any additional information relevant to the case’s possible source of exposure