

Demographic and Contact Information

Patient Surname:		First Name:	PHN:
Birthdate: (e.g. 15/Dec/07)	Sex: F <input type="checkbox"/> M <input type="checkbox"/>	Respondent is: Case <input type="checkbox"/> Parent or Guardian <input type="checkbox"/> Other <input type="checkbox"/>	
Address: (street, city, postal code)		Home phone:	
Type of residence: Apartment <input type="checkbox"/> House <input type="checkbox"/> Townhouse <input type="checkbox"/> Other <input type="checkbox"/>		Work: Cell: E-mail:	
Occupation:		Company:	
Address:			
Physician(s):		Physician Phone:	

Case Notification/Assignment

Report Received at HU: (e.g. 15/Dec/07)	
Contact attempts (date and time)	Interview?
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
Interviewer: <input type="checkbox"/> Not located	

Clinical Information – Lab Information

	Urine Antigen Testing	Culture	Serology	PCR	Other lab information (X-ray results, etc.):
	Conducted: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Positive <input type="checkbox"/> Negative <input type="checkbox"/>	Conducted: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Positive <input type="checkbox"/> Negative <input type="checkbox"/> Species: Serogroup:	Conducted: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Acute Titre: Convalescent Titre:	Conducted: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Positive <input type="checkbox"/> Negative <input type="checkbox"/>	
Date specimen collected:			Acute: Convalescent:		
Type of specimen:					
Name of testing lab:					

Clinical Information – Case History

Onset of Earliest Symptom (e.g. 15/Dec/07) Time: _____ am/pm	Earliest Symptom(s):	Lab Report Date: (e.g. 15/Dec/07)	Reporting Lab:
Diagnosis: Legionnaire's Disease <input type="checkbox"/> Pontiac Fever <input type="checkbox"/>		Hospitalized for Current Illness: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Name of Hospital:
Symptoms: <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Myalgia <input type="checkbox"/> Diarrhea <input type="checkbox"/> Anorexia <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Other:		Date of Admission (e.g. 15/Dec/07)	Date of Discharge (e.g. 15/Dec/07):
		Admitted to ICU: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Deceased: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
Additional clinical information:			

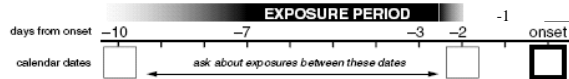
Medical History and Underlying Conditions

Does the case have underlying medical conditions. (e.g. respiratory, cancer, immuno-compromising, others): <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Specify:
Does the case smoke?: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If Yes, for how long? _____ Has the case ever smoked? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If Yes, for how long? _____
Is the case on immunosuppressive medication? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK Specify:
Additional Information:

BC Legionella Infection Follow-Up Form

Exposure Period

Enter onset date in heavy box.
Count back to figure the
probable exposure period.



Note: Exposure period for Legionnaire's Disease is 2-10 days (5-6 days is most common) and for Pontiac Fever is 5-66 hours (24-48 hours is most common)

Travel

Travel during exposure period?: Y N DK

If yes: Within BC Within Canada Outside Canada

Departure (e.g. 15/Dec/07): _____ Return (e.g. 15/Dec/07): _____

Destination(s) (e.g. city, mode of travel): _____ Where did case stay during travel? (e.g. name of hotel) _____

Activities during travel: _____

Exposures

Water:

Exposure		Location/Details	Exposure		Location/Details
Shower/ bathe at home	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Frequency:	Fountain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Shower/bathe outside of home (gyms, hotels, spas, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Frequency:	Sprinklers	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Air conditioner	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Dental work	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Humidifier	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Respiratory therapy device (e.g. ventilator, nebulizer, intubation)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Hot tub/ jacuzzi/ whirlpool/ other spa pool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Proximity to cooling tower	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Pool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Other source of sprayed water	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Car wash/ Power washer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK				
Additional details on water exposures:					

Regular Activities

Activity	Name	Location	Frequency/Routine
Grocery shopping			
Other shopping			
Eating or drinking outside of the home (restaurants, pubs, take-out, etc.)			
Indoor Recreation: (fitness centre, gym organized classes, clubs, social events)			
Outdoor Recreation (sports, walking, etc.)			

BC *Legionella* Infection Follow-Up Form

Social events or gatherings (weddings, potluck, fairs, etc.)			
Volunteering			
Gardening			
Exposure to soil excavation			

Hospitals and Care Facilities (during incubation period):

Type of Facility: Hospital Long-Term Care Assisted Living Residential/Group Home Other Specify:

Admitted: Y N DK Visited: Y N DK Lived in: Y N DK Worked in: Y N DK

Name and location of Hospital(s)/Facility(s):

Date(s) of Admission/Visit (e.g. 15/Dec/07): Date of Discharge (e.g. 15/Dec/07):
 Unit/ward (type of unit/#/name):

Additional details:

Is the Case or interviewee aware of any other individuals who have had similar symptoms recently? Y N DK

If yes, please provide the following information:

Name	Nature of contact (family, friend, colleague)	Contact Information

Notes

Date	Comment	Initials

If you require more space for further notes and details please feel free to use additional pages.