BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

# Legionellosis Case Report Form

**Confidential when completed**

| PERSON REPORTING | |
|---|---|
| Health Authority: ☐ FHA ☐ IHA ☐ VIHA ☐ NHA ☐ VCH | |
| Name: *Last* *First* | Phone Number: ( ) - ext. |
| Email: | Date case report form completed : *YYYY / MM / DD* |

## A. Client Information

| | | | |
|---|---|---|---|
| Name: *Last* *First* *Middle* | | | Alternate Name(s): |
| PHN: | Date of Birth: *YYYY / MM / DD* | Sex: ☐Male ☐ Female | |
| Home Address: *Unit #* *Street #* *Street Name* | | City: | |
| Postal code: | Province: | Phone number (home/office/cell) ( ) - ext. | |
| Occupation: | Employer: | Work address: | |
| Email: | Physician Name *Last* *First* | Physician Phone Number: | |

## B. CLINICAL INFORMATION

Date of onset of symptoms *YYYY / MM / DD* *Time* *AM / PM*

**Signs and Symptoms**

| | | | |
|---|---|---|---|
| ☐ Cough | ☐ Myalgia | ☐ Abdominal Pain | ☐ Shortness of breath |
| ☐ Diarrhea | ☐ Fever | ☐ Anorexia | ☐ Headache |
| ☐ Other: | Diagnosis: ☐ Legionnaire's Disease ☐ Pontiac Fever | | |

**Outcome**

Admitted to hospital ☐ Yes ☐ No ☐ U Hospital Name: Date of Admission *YYYY / MM / DD* Date of Discharge *YYYY / MM / DD*

Admitted to ICU: ☐ Yes ☐ No ☐ U

Death: ☐ Yes ☐ No ☐ U

## C. MEDICAL HISTORY AND UNDERLYING CONDITIONS

Does the case have underlying medical conditions. (e.g. respiratory, cancer, immuno-compromising, others): ☐ Yes ☐ No ☐ U
Specify:

Does the case smoke?: ☐ Yes ☐ No ☐ U If Yes, for how long? _____

Has the case ever smoked? ☐ Yes ☐ No ☐ U If Yes, for how long? _____

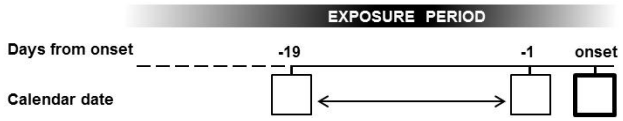
Is the case on immunosuppressive medication? ☐ Yes ☐ No ☐ U
Specify:

Additional Information:

## D. LABORATORY INFORMATION

| Lab test | Specimen type | Date specimen collected | Name of testing lab | Lab Report date | Results |
|---|---|---|---|---|---|
| Urine Antigen Testing<br>Conducted:<br>☐ Yes ☐ No ☐ U | | *YYYY / MM / DD* | | *YYYY / MM / DD* | Positive ☐<br>Negative ☐ |
| Culture<br>Conducted:<br>☐ Yes ☐ No ☐ U | | *YYYY / MM / DD* | | *YYYY / MM / DD* | Positive ☐<br>Negative ☐<br>Species:<br>Serogroup: |
| Serology<br>Conducted:<br>☐ Yes ☐ No ☐ U | | Acute:<br>*YYYY / MM / DD*<br>Convalescent:<br>*YYYY / MM / DD* | | *YYYY / MM / DD* | Acute Titre:<br>Convalescent Titre: |
| PCR<br>Conducted:<br>☐ Yes ☐ No ☐ U | | *YYYY / MM / DD* | | *YYYY / MM / DD* | Positive ☐<br>Negative ☐ |
| Others lab information (X-ray results, etc.): | | | | | |

## E. RISK FACTORS & EXPOSURE INFORMATION




**Note**: Exposure period for Legionnaire's Disease is 1-19 days and for Pontiac Fever is 5-66 hours (24-48 hours is most common)

**Travel**

Infection acquired during travel: ☐ Yes ☐ No ☐ U  If Yes, ☐ within BC ☐ within Canada ☐ outside Canada

Was travel confirmed as the most likely source of infection? ☐

| Dates: DEPARTURE | Dates: RETURN | Locations (E.g., city, country, resort) | Mode of travel | Foods brought back |
|---|---|---|---|---|
| | | | | |

**Water**

| Exposures | | Location/Details | Exposures | | Location/Details |
|---|---|---|---|---|---|
| Shower/bathe at home | ☐ Yes ☐ No ☐ U | Frequency: | Fountain | ☐ Yes ☐ No ☐ U | Specify other: |
| Shower/bathe outside of home (gyms, hotels, spas, etc.) | ☐ Yes ☐ No ☐ U | Frequency: | Sprinklers | ☐ Yes ☐ No ☐ U | |
| Air conditioner | ☐ Yes ☐ No ☐ U | | Dental work | ☐ Yes ☐ No ☐ U | |
| Humidifier | ☐ Yes ☐ No ☐ U | | Respiratory therapy device (e.g. ventilator, nebulizer, intubation) | ☐ Yes ☐ No ☐ U | |
| Hot tub/ jacuzzi/ whirlpool/ other spa pool | ☐ Yes ☐ No ☐ U | | Proximity to cooling tower | ☐ Yes ☐ No ☐ U | |
| Pool | ☐ Yes ☐ No ☐ U | | Other source of sprayed water | ☐ Yes ☐ No ☐ U | |
| Car wash/ Power washer | ☐ Yes ☐ No ☐ U | | | | |
| Additional details on water exposures: | | | | | |

**Regular Activities**

| Activity | Name | Location | Frequnecy/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.) | | | |
| 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: ☐ Yes ☐ No ☐ U Visited: ☐ Yes ☐ No ☐ U Lived in: ☐ Yes ☐ No ☐ U Worked in: ☐ Yes ☐ No ☐ U

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:

## F. CONTACTS

Is the Case or interviewee aware of any other individuals who have had similar symptoms recently? ☐ Yes ☐ No ☐ U

If yes, please provide the following information:

| Name | Date Ill | Nature of contact* | Contact phone |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Household, sexual, close contacts*

## G. NOTES

| Date | Comment | Initials |
|---|---|---|
| | | |
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| | | |
| | | |
| | | |
| | | |
| | | |

*Date Report Received at HU (YYYY/MM/DD)*

| *Contact attempts (date and time)* | *Interview?* |
|---|---|
| *1.* | ☐ |
| *2.* | ☐ |
| *3.* | ☐ |
| *4.* | ☐ |

*Interviewer:* ☐ *Not located*