Case ID: _____

Legionnaires' Disease Medical Record Abstraction Form Template

Abstractor name: _____ Today's date: _____

Information source *<Check all that apply>*
☐ Hospital chart ☐ Electronic medical records ☐ Staff interview ☐ Patient interview
☐ Emergency department or clinic chart ☐ Proxy interview
☐ Other *<If other, specify>*:_____

Medical record number: _____ Healthcare facility: _____

Patient information

Name: _____ Sex: ☐ M ☐ F

Date of birth: _____ Age (on admission or symptom onset): _____

Race/Ethnicity *<Check all that apply>*:
☐ American Indian/Alaska Native ☐ Native Hawaiian or other Pacific Islander
☐ Asian ☐ White
☐ Black or African American ☐ Unknown

Ethnicity:
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

Type of Residence:
☐ Home ☐ Long-term care facility ☐ Senior-living facility ☐ Assisted living facility
☐ Other *<If other, specify>*: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Alt. phone: _____

What was the patient's outcome? ☐ Recovered ☐ Still ill ☐ Died ☐ Unknown

Proxy contact information *<List proxy contact information if patient is unable to be interviewed or has died.>*

Name: _____ Relationship to patient: _____

Phone: _____ Alt. phone: _____

***Legionella*-specific testing**

Respiratory specimen collected and processed for *Legionella*-specific culture?
☐ Yes ☐ No ☐ Unknown
If yes, specimen type (e.g., expectorated sputum, BAL): _____
Date collected: _____ Lab name: _____
Results: _____

If no, respiratory specimen collected for any culture?
☐ Yes ☐ No ☐ Unknown
If yes, specimen type (e.g., expectorated sputum, BAL): _____
Date collected: _____ Lab name: _____
Results: _____

Urine specimen collected for *Legionella* urinary antigen testing?
☐ Yes ☐ No ☐ Unknown
If yes, date collected: _____ Lab name: _____
Results: _____

PCR testing for *Legionella*?
☐ Yes ☐ No ☐ Unknown
If yes, specimen type (e.g., expectorated sputum, BAL): _____
Date collected: _____ Lab name: _____
Results: _____

Acute (initial) serum sample collected for *Legionella* serologic testing?
☐ Yes ☐ No ☐ Unknown
If yes, date collected: _____ Lab name: _____
Type of assay (e.g., Lp1 only, Lp1-6 pooled antigen, *Legionella* spp. pooled antigen): _____
Results: _____

Convalescent serum samples collected for *Legionella* serologic testing?
☐ Yes ☐ No ☐ Unknown
Date collected: _____ Lab name: _____
Date collected: _____ Lab name: _____
Results: _____

Other *Legionella* testing?
☐ Yes ☐ No ☐ Unknown
Date collected: _____ Lab name: _____
Type of test: _____
Results: _____

Case ID: _____

Signs and symptoms

<The following sections apply to the patient's hospitalization or medical care received for the treatment of symptoms compatible with Legionnaires' disease (or Pontiac fever). Check all that apply.>

☐ Shortness of breath	☐ Cough
☐ Hemoptysis (coughing up blood)	☐ Fever >100.4°F
☐ Diarrhea (3 stools/24 h)	☐ Nausea or vomiting
☐ Altered mental status (confusion)	☐ Myalgia (body aches)
☐ Malaise (discomfort)	☐ Headache
☐ Other: _____	☐ Other: _____

<If the patient did not have prior respiratory symptoms, choose the onset date of cough or shortness of breath, whichever occurs first. Otherwise, use the earliest date when other symptoms compatible with Legionnaires' disease began. For Pontiac fever cases, use the earliest date when fever, myalgia (body aches) or headache began.>

Date of earliest symptom onset: _____

Comments: _____

Radiographic findings

<Review any radiographic findings 14 days after onset of symptoms above. If multiple chest images are available, report the first for which evidence of pneumonia is noted.>

Evidence of pneumonia on radiographic exam?
☐ Yes ☐ No ☐ Unknown
If yes, ☐ Chest x-ray ☐ CT scan Date: _____

Result: *<Check all that apply from radiology report>*

☐ Pneumonia/bronchopneumonia	☐ Pleural effusion
☐ Consolidation	☐ Pneumonitis
☐ Lobar (NOT interstitial) infiltrate	☐ Pulmonary edema
☐ Single lobar	☐ Interstitial infiltrate
☐ Multiple lobar infiltrate (unilateral)	☐ Empyema
☐ Multiple lobar infiltrate (bilateral)	☐ ARDS (acute respiratory distress syndrome)
☐ Air space/alveolar density/opacity/disease	☐ Normal
☐ Atelectasis	☐ Cannot rule out pneumonia
☐ Cavitation	☐ Report not available
☐ Other (specify: _____)	

Comments: _____

Case ID: _____

Case classification

☐ Legionnaires' disease ☐ Pontiac fever
☐ Extrapulmonary legionellosis (specify site: _____)

☐ Confirmed case ☐ Suspect case ☐ Probable case

Medical history

☐ COPD/emphysema/chronic lung disease
☐ Asthma
☐ Diabetes
☐ Congestive heart failure
☐ Chronic renal insufficiency (CRI/CKD) or end-stage renal disease (ESRD)
☐ Cirrhosis/liver disease
☐ History of stroke/CVA
☐ Dementia
☐ HIV/AIDS (CD4 count: _____ Date: _____)
☐ Other immunosuppressive condition (e.g., immunoglobulin deficiency, splenectomy, sickle cell anemia) (Specify: _____)
☐ Solid organ transplant (Type:_____ Date: _____)
☐ Bone marrow transplant (Type:_____ Date: _____)
☐ Cancer, hematologic (Type: _____)
☐ Cancer, solid organ (Type: _____)
☐ History of chemotherapy (Date of last treatment: _____)
☐ History of radiation (Date of last treatment: _____)
☐ Other immunosuppressive therapy (e.g., systemic steroids, anti-rejection medications, biologic therapy) (Specify: _____)
☐ Dysphagia, aspiration risk
☐ History of pneumonia in prior year (Date: _____)
☐ Other (Specify: _____)
☐ Other (Specify: _____)

Behaviors	***<Check one:>***		**Quantity per day (packs or drinks)**	**Duration (years)**
	Yes	**No**		
Current smoker?				
Former smoker?				
Consume alcohol?				

History of other substance abuse:
☐ Yes ☐ No ☐ Unknown
If yes, specify substance(s): _____

Antibiotic therapy

<Check all that apply during or preceding treatment for Legionnaires' disease>

Therapy	**Dose**	**Route**	**Start date**	**End date**	**Continued as outpatient? *<Check if yes>***
☐ Levofloxacin (Levaquin)					
☐ Moxifloxacin					
☐ Ciprofloxacin (Cipro)					
☐ Azithromycin (Zithromax)					
☐ Erythromycin					
☐ Ceftriaxone (Rocephin)					
☐ Rifampin					
☐ Rifapentine					
☐ Linezolid					
☐ Tetracycline					
☐ Doxycycline					
☐ Vancomycin					
☐ Piperacillin-tazobactam (Zosyn)					
☐ Other (specify): _____					
☐ Other (specify): _____					

Clinical outcomes

Hospitalized:
☐ Yes ☐ No ☐ Unknown
If yes, dates: _____

ICU stay:
☐ Yes ☐ No ☐ Unknown
If yes, dates: _____
If yes, intubated? ☐ Yes ☐ No ☐ Unknown

Disposition:
☐ Still hospitalized
☐ Discharged home (Date: _____)
☐ Transferred to another facility (Date: _____ Name: _____)
☐ Deceased (Date: _____)

☐ Unknown

Discharge diagnosis:
☐ Legionnaires' disease
☐ Pneumonia
If yes, etiology: _____ Lab test(s): _____
☐ Other diagnosis: _____

<The following sections apply to the patient's healthcare exposures before the onset of symptoms compatible with Legionnaires' disease (or Pontiac fever).>

Exposure information

<Important: Use a calendar to calculate exposure period! Start at the date of earliest symptom onset documented above and count backwards 14 days. See example below.>

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1	2	3 **1st day of exposure period**	4	5
6	7	8	9	10	11	12
13	14	15	16	17 **Date of onset**	18	19

<Document exposure period here: _____ to _____.>

<Document the patient's healthcare exposures for each day during his/her exposure period, starting with the first day listed above. Additional details regarding specific location(s) will be addressed below.>

#	Date(s)	Type of healthcare exposure*	Name/location of healthcare facility
1			
2			
3			
4			
5			

* *<Specify whether inpatient, outpatient, resident, visitor, volunteer or employee>*

Case ID: _____

Case classification (according to surveillance or outbreak case definition):

☐ Presumptive healthcare-associated ☐ Possible healthcare-associated ☐ Not healthcare-associated

<If not healthcare-associated, END HERE. Otherwise, continue.>

Exposure information for possible exposures in inpatient healthcare settings

<Beginning the first day of the exposure period, complete the following sections for each inpatient healthcare exposure in the 14 days before date of symptom onset, duplicating the template as needed. If the patient had only outpatient or other exposures, skip to the appropriate section below.>

Healthcare exposure #: _____ Facility name: _____

Address: _____

Admission date: _____ Discharge date: _____

Chief complaint/reason for admission: _____

Discharge diagnosis: _____

<List specific locations, dates, and reasons for each inpatient location at this facility during exposure period.>

Building	Room #	Date(s)	Reason

Was the patient ambulatory? ☐ Yes ☐ No ☐ Unknown

If yes, did the patient leave the building during hospitalization? ☐ Yes ☐ No ☐ Unknown

If yes, indicate locations and dates: _____

Did the patient shower? ☐ Yes ☐ No ☐ Unknown

If yes, list applicable building/rooms:

_____

Was the patient intubated? ☐ Yes ☐ No ☐ Unknown
If yes, list applicable building/rooms:

_____

Did the patient use respiratory therapy equipment? ☐ Yes ☐ No ☐ Unknown
If yes, list applicable building/rooms:

Did the patient use a therapy tub? ☐ Yes ☐ No ☐ Unknown
If yes, list applicable building/rooms:

Did the patient receive wound care? ☐ Yes ☐ No ☐ Unknown
If yes, list applicable building/rooms:

Did the patient receive ice from a healthcare facility's ice machine? ☐ Yes ☐ No ☐ Unknown
If yes, list applicable building/areas:

Comments:

Exposure information for possible exposures in outpatient healthcare settings

<Beginning the first day of the exposure period, complete this section for each outpatient visit in the 14 days before date of symptom onset, duplicating the template as needed. If the patient had other exposures, skip to the "Other Exposures" section below.>

<List specific locations, dates, and reasons for each outpatient healthcare visit during exposure period.>

Clinic/building	Address	Room #	Date(s) of visit	Reason for visit

Other exposures

Did the patient have any other exposure to the facility in the 14 days before date of symptom onset?
☐ Yes ☐ No ☐ Unknown

If yes, please note each possible exposure, being as specific as possible with locations and dates:
