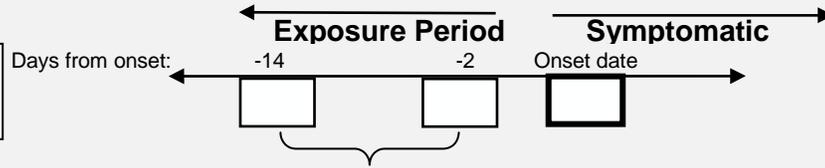


Infection Timeline

Enter onset date in box, then count back to determine probable exposure period and enter those dates.



If not otherwise specified, please ask about exposures 2-14 days before symptom onset.

Clinical Description (Yes=Y; No=N; Unknown=U)

Did the case have symptoms?: Y N U **if yes, onset date: ___/___/_____ Time: _____AM / PM*

Did the case have?:

Fever (max temp)_____	Y	N	U	Headache	Y	N	U	Body aches	Y	N	U
Shortness of breath	Y	N	U	Cough	Y	N	U	Chills	Y	N	U
Other_____	Y	N	U								

How many days did the illness last? _____days

Was the case told by a health care provider that they had pneumonia? Y N U

At the time of diagnosis, did the case reside at:

Private home/residence?	Y	N	U	
Long term care facility?	Y	N	U	
Hospital?	Y	N	U	
Other health care facility/clinic?	Y	N	U	details: _____
Other:	Y	N	U	details: _____

Did case receive antibiotics for this illness? Y N U Antibiotic name: _____
 Antibiotic name: _____
 Antibiotic name: _____

Outcome: Survived Died Unknown
If died, date of death: ___/___/_____

Was case hospitalized? Yes No Unknown (ER visits only not considered "hospitalized")
If hospitalized Hospital Name: _____
 Date of Admission: ___/___/_____ Date of Discharge: ___/___/_____
 Transferred to another hospital? Yes No Unknown
 Transfer hospital name: _____

Did case have a previous hospitalization 2-14 days **prior to** symptom onset? Yes No Unknown
If hospitalized Hospital Name: _____
 Date of Admission: ___/___/_____ Date of Discharge: ___/___/_____
 Transferred to another hospital? Yes No Unknown
 Transfer hospital name: _____

School/Work

Occupation: _____ Student? Yes No
 Place of Employment: _____ If yes, Name of School: _____

Does the case...

Work with heating, ventilation, or air conditioning (HVAC) equipment?	Yes	No	Unknown
Work with swimming pools, whirlpool/spas/hot tubs, or recreational water?	Yes	No	Unknown
Work in, volunteer <u>or visit</u> a hospital, LTCF, assisted living, or nursing home?	Yes	No	Unknown
Work in, volunteer <u>or visit</u> a dentist's office or clinic?	Yes	No	Unknown

If yes, details: _____

Residence Exposures

During the period 2-14 days prior to diagnosis, where did the case reside:

Private home/residence?	Y	N	U	
Long term care facility?	Y	N	U	
Hospital?	Y	N	U	
Other health care facility/clinic?	Y	N	U	details: _____
Other:	Y	N	U	details: _____

Travel Information

Did case travel outside the U.S. in the 2-14 days prior to onset of illness? Yes No Unknown

<i>If yes,</i>	City/Country	Date Left US	Date Returned to US	Hotels	Water Exposures?
(1)	_____	_____	_____	_____	_____
(2)	_____	_____	_____	_____	_____
(3)	_____	_____	_____	_____	_____
(4)	_____	_____	_____	_____	_____
(5)	_____	_____	_____	_____	_____

Did case travel within the U.S. in the 2-14 days prior to onset of illness? Yes No Unknown

<i>If yes,</i>	City/State	Date Arrived	Date Departed	Hotels	Water Exposures?
(1)	_____	_____	_____	_____	_____
(2)	_____	_____	_____	_____	_____
(3)	_____	_____	_____	_____	_____
(4)	_____	_____	_____	_____	_____
(5)	_____	_____	_____	_____	_____

Water Exposures

In the 2-14 days prior to onset of illness did the case have exposure to any of the following, either traveling or at home:

Supplemental oxygen (CPAP, BiPAP, etc.) or nebulizer?	Yes	No	Unknown
Ice machine?	Yes	No	Unknown
Centralized cooling tower/HVAC systems?	Yes	No	Unknown
Home plumbing repairs?	Yes	No	Unknown
Home humidifier or mister?	Yes	No	Unknown
Swamp cooler?	Yes	No	Unknown
Recreational mister, store mister (gardening or grocery store) ?	Yes	No	Unknown
Hot springs or mineral baths?	Yes	No	Unknown
Swimming pool, wading pool, or water park/"splash pad"?	Yes	No	Unknown
Hot tub, whirlpool spa, (includes sitting NEAR but not in)?	Yes	No	Unknown
Steam room or wet sauna?	Yes	No	Unknown
Decorative fountain or water display?	Yes	No	Unknown
Shower (away from home only)?	Yes	No	Unknown
Conference center, meeting, or event?	Yes	No	Unknown
Dentists office or another clinic?	Yes	No	Unknown
Car wash?	Yes	No	Unknown

If yes, details/notes:

Contacts management

Are any members of your immediate residence (family members, roommates, guests) or any persons you associated with or traveled with the last 2-14 days ill with a similar respiratory illness or pneumonia?

Yes No Unk

If yes:

Name	Age	Similar Illness	Onset (m d y)	Comments
_____		Y N U	____/____/____	_____
_____		Y N U	____/____/____	_____
_____		Y N U	____/____/____	_____
_____		Y N U	____/____/____	_____
_____		Y N U	____/____/____	_____

If yes:

Did any of these persons seek medical care or undergo testing for Legionella?

Name	Age	Similar Illness	Hospital/Clinic
_____		Y N U	_____
_____		Y N U	_____
_____		Y N U	_____
_____		Y N U	_____
_____		Y N U	_____

Epi-links

Is any person listed above already a confirmed or suspected case in CEDRS? Yes No Unk *If yes, CEDRS#* _____

Is this case part of a known/suspected outbreak? Yes No Unk *If yes, specify:* _____

Summary of follow up

- Complete form sent to CDPHE
- Prevention education provided (found at <http://www.cdc.gov/legionella/about/index.html>)
- Follow up with other household members
- Other: _____