



Admitted to ICU: Yes No Unknown

Details on hospitalization:

Outcome

Death: Yes No Unknown *If yes, death date:* _____
YYYY / MM / DD

D. MEDICAL HISTORY AND UNDERLYING CONDITIONS

Underlying medical conditions. (e.g. respiratory, cancer, immuno-compromising, others)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specify
Current tobacco smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, for how long? _____
Ever smoked tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, for how long? _____
Treatment that weakens the immune system	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Specify

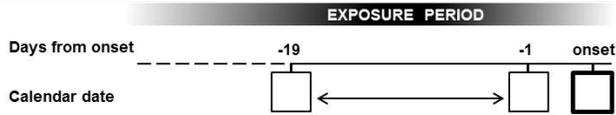
Additional Information:

E. LABORATORY INFORMATION

Lab test	Specimen type	Date specimen collected	Lab Report date	Results
Urine antigen	URINE	YYYY / MM / DD	YYYY / MM / DD	Positive <input type="checkbox"/> Species: <i>pneumophila</i> Serogroup: 1
Culture		YYYY / MM / DD	YYYY / MM / DD	Growth detected/identified <input type="checkbox"/> Negative <input type="checkbox"/> Species: _____ Serogroup: _____
Serology	SERUM	Acute: YYYY / MM / DD Convalescent: YYYY / MM / DD	YYYY / MM / DD YYYY / MM / DD	Acute titre: Convalescent titre: Species: <i>pneumophila</i>
Nucleic acid test (NAT) including PCR and respiratory panel		YYYY / MM / DD	YYYY / MM / DD	Positive <input type="checkbox"/> Negative <input type="checkbox"/> Species: <i>pneumophila</i> Serogroup: _____



F. RISK FACTORS AND 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

Travel during exposure period: Yes No Unknown *If Yes:* within BC* outside BC but within Canada** outside Canada**

*report travel in BC to HA where travel occurred

**report all travel outside of BC to BCCDC

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

Dates: DEPARTURE	Dates: RETURN	Location- Address	City	Country	Postal code	Hotel/resort name	Additional details
YYYY / MM / DD	YYYY / MM / DD						
YYYY / MM / DD	YYYY / MM / DD						
YYYY / MM / DD	YYYY / MM / DD						
YYYY / MM / DD	YYYY / MM / DD						
YYYY / MM / DD	YYYY / MM / DD						



F. RISK FACTORS AND EXPOSURE INFORMATION *continued*

Environmental

Exposure	Exposed	Location/Details	Exposure	Exposed	Location/Details
Shower/bathe at home	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Sprinklers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Shower/bathe outside of home (gyms, hotels, spas, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Dental work	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Air conditioner	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Respiratory therapy device (e.g. ventilator, nebulizer, intubation)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Humidifier	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Car wash/ Power washer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Hot tub/ jacuzzi/ whirlpool/ other spa/pool	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Other source of sprayed water	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Pool	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Gardening	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Fountain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Soil/compost	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	

Hospitals and Care Facilities*

*Report to ICP or HA of hospital location

Type of facility	Name	Address	City	Postal code	Type of exposure	Dates (yyyy/mm/dd)	Details (e.g., unit/ward or exposures)
<input type="checkbox"/> Hospital <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Assisted Living <input type="checkbox"/> Residential/Group Home <input type="checkbox"/> Other Specify:					<input type="checkbox"/> Admitted <input type="checkbox"/> Visited <input type="checkbox"/> Lived in <input type="checkbox"/> Worked in <input type="checkbox"/> Other	Admission: Discharge: Visit/work:	
<input type="checkbox"/> Hospital <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Assisted Living <input type="checkbox"/> Residential/Group Home <input type="checkbox"/> Other Specify:					<input type="checkbox"/> Admitted <input type="checkbox"/> Visited <input type="checkbox"/> Lived in <input type="checkbox"/> Worked in <input type="checkbox"/> Other	Admission: Discharge: Visit/work:	
<input type="checkbox"/> Hospital <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Assisted Living <input type="checkbox"/> Residential/Group Home <input type="checkbox"/> Other Specify:					<input type="checkbox"/> Admitted <input type="checkbox"/> Visited <input type="checkbox"/> Lived in <input type="checkbox"/> Worked in <input type="checkbox"/> Other	Admission: Discharge: Visit/work:	



Please record additional addresses of locations where notable time was spent or notable exposure occurred. These will be added to generate weekly alerts and maps.

Address type	Name	Address	City	Postal code
Work/school/daycare				
Other:				
Other:				
Other:				

G. OTHERS EXPOSED

Use table to record others who may have been exposed to the same source as the case under investigation

Name	Date ill	Nature of exposure	Contact phone

H. Additional Details Related to Case Investigation

Date	Comments	Initials

BC Case Definition for *Legionella* infection

A confirmed case of legionellosis is defined as a clinical illness* with laboratory confirmation of infection:

- isolation of *Legionella* sp. from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluids **OR**
- a significant (e.g. fourfold or greater) rise in *Legionella* sp. IgG titre between acute and convalescent sera **OR**
- seroconversion from non-reactive to IgG or IgM reactive or from IgM reactive to IgG reactive
- demonstration of *L. pneumophila* antigen in urine **OR**
- demonstration of *Legionella* spp. DNA by NAT from respiratory secretions, lung tissue, pleural fluid, or other normally sterile fluids.

*Clinical illness is defined as two distinct illnesses: Legionnaires' disease, characterized by fever, myalgia, cough and pneumonia, and Pontiac fever, a milder illness without pneumonia.