**Legionellosis Investigation Form**

**\***Information required for NNDSS core data set. No enhanced surveillance data are collected at the national level.

**🗆 *L. pneumophila* \* 🗆 *L. longbeachae\** 🗆 Unspecified\* 🗆 Other-specify\*………………….……**

**Public Health Unit**  Outbreak ID\*:

Completed by:

Telephone: Fax:

**NOTIFICATION:**

Date PHU notified: ......../......../........ Date initial response: ......../......../........

Notifier: Organisation:

Telephone: Fax: Email:

Treating Dr:

Telephone: Fax: Email:

**CASE DETAILS:** **UR No:**

Name:

 *First name Surname*

Date of birth\*: ......./......../........Age\*: Years\* Months\* Sex\*: 🗆 Male 🗆 Female

Name of parent/carer:

🗆 Aboriginal\* 🗆 Torres Strait Islander\* 🗆 Aboriginal & Torres Strait Islander\* 🗆 Non-Indigenous\* 🗆 Unknown\*

English preferred language: 🗆 Yes 🗆 No – *specify* Ethnicity – *specify*

Permanent address:

 Postcode\*:

Home telephone: Mobile: Email:

Occupation: Work telephone:

Temporary address *(if different from permanent address)*:

 Postcode:

Telephone: Mobile: Email:

General Practitioner: Dr

Address: Postcode:

Telephone: Fax: Email:

**CLINICAL DETAILS:**

Date of onset\*: ......../......../....... Date of first consultation: ......../......../.......

Fever 🗆 Yes 🗆 No 🗆 Unknown

Cough 🗆 Yes 🗆 No 🗆 Unknown

Pneumonia 🗆 Yes 🗆 No 🗆 Unknown *If yes, radiologically confirmed?* 🗆 Yes 🗆 No 🗆 Unknown

Other clinical symptoms *(please tick)*:

🗆 Headache 🗆 Anorexia 🗆 Malaise 🗆 Nausea 🗆 Vomiting 🗆 Confusion 🗆 Myalgia 🗆 Diarrhoea

🗆 Other – *specify*

Hospitalised: 🗆 Yes 🗆 No 🗆 Unknown Hospital: Date: ......../......../........ to ......../......../........

Admitted to ICU: 🗆 Yes 🗆 No 🗆 Unknown Hospital: Date: ......../......../........ to ......../......../........

Complications: 🗆 Yes – *specify* 🗆 No 🗆 Unknown

Outcome: 🗆 Survived 🗆 Died of condition\* Date of death: ......../......../........ 🗆 Unknown

**LABORATORY\*:**

Public Health Units should encourage sputum (or, where available, bronchial washing, induced sputum or lung biopsy) culture to be sent to the state reference laboratory for typing and to enable matching of any isolates with any available environmental samples.

Laboratory: ……………………….……… First collection date: ......./......../........

Isolation of Legionella: 🗆 Yes -*specify site* ……………………… 🗆 No 🗆 Not done

Legionella urinary antigen: 🗆 Detected 🗆 Not detected 🗆 Not done

Legionella PCR/NAT: 🗆 Detected -*specify site* ……………… 🗆 Not detected 🗆 Not done

🗆 Fourfold rise in titre: 1st  Date: ......../......../........ 2nd Date: ......../......../........

🗆 Single high titre (≥512): Date: ......../......../........

**RISK FACTORS:**

Age ≥ 50 years: 🗆 Yes 🗆 No 🗆 Unknown

Smoker: 🗆 Yes 🗆 No 🗆 Unknown

 🗆 Current smoker

 🗆 Ex-smoker Year quit ………….. No. of years a smoker …………

Chronic disease: 🗆 Yes 🗆 No 🗆 Unknown *If yes, specify below (please tick)*:

 🗆 Respiratory 🗆 Chronic renal disease 🗆 Cardiac 🗆 Diabetes

🗆 Other ……………………………………………………………

Immunocompromised: 🗆 Yes 🗆 No 🗆 Unknown *If yes, specify below (please tick)*:

 🗆 Immunosuppressive medications (e.g. Corticosteroids) – *specify* ………………………………

 🗆 Oncology treatment 🗆 Transplant recipient

Other risk factors: 🗆 Yes – *specify* ……………………………………………………………… 🗆 No

**EXPOSURE PERIOD:**

**Date: ......../......../........**  to **Date: ......../......../........**

 (Onset of symptoms – 10 days) (Onset of symptoms – 2 days)

**EXPOSURES FOR *L. pneumophila***

**ENVIRONMENTAL EXPOSURES:** (include all exposures within the exposure period)

|  |  |  |
| --- | --- | --- |
| **Potential exposure sources** | **Exposure history** | **If Yes to any exposure source, please provide details below** |
| **Name of place or device, address/location and dates visited or used** |
| Hospitalised (cooling water systems, warm water systems, respiratory devices, NG tubes)  | 🗆 Yes 🗆 No 🗆 Unknown | Hospital: ………………………………………………………… Ward:……………………….. Admission date: ......../......../........ Discharge date: ......../......../........ |
| Resided in a residential care facility (including temporary or respite care) | 🗆 Yes 🗆 No 🗆 Unknown | Facility: ………………………………………………………………………………………………  |
| Shops and shopping complexes(cooling water systems)  | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Clubs, cinemas, hospitals (as a visitor), hotels, conference facilities(cooling water systems)  | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Pools/aquatic centres, spas (including home spas), water parks | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Water fountains or sprinklers (including overhead misting sprinkler systems) | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Car/truck wash | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Dental treatment | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Humidifier, nebulisers or other respiratory devices  | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Other – consider CBD, industrial/building sites, sporting venues , aquariums, water misters | 🗆 Yes 🗆 No 🗆 Unknown |  |

**TRAVEL DETAILS:** (include any travel within exposure period)

|  |  |
| --- | --- |
| **Travel history** | **If Yes to any travel, please provide details below** |
| **Dates travelled** | **Country/State visited** | **Places visited (e.g. hotels stayed)** |
| Domestic (within Australia) | 🗆 Yes 🗆 No 🗆 Unknown |  |  |  |
|  |  |  |
|  |  |  |
| Overseas | 🗆 Yes 🗆 No 🗆 Unknown |  |  |  |
|  |  |  |
|  |  |  |

**EXPOSURES FOR *L. longbeachae***

**GARDENING EXPOSURES:** (include all exposures within the exposure period)

|  |  |  |
| --- | --- | --- |
| **Exposure source** | **Exposure history** | **If Yes, please provide details below** |
| **Name of place or brand, address/location and relevant dates**  |
| General gardening activities | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Washed hands routinely after gardening activities | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Use potting mix or landscaping materials | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Prior knowledge of risks from potting mix or landscaping materials  | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Wore gloves | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Wore mask | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Watered hanging baskets | 🗆 Yes 🗆 No 🗆 Unknown |  |
| Visited a plant nursery/gardening centre/landscaping centre | 🗆 Yes 🗆 No 🗆 Unknown |  |

**PLACE ACQUIRED:**

🗆 Within the state 🗆 Other Australian state/territory – *specify*

 🗆 Other country – *specify* ………………………………………. 🗆 Unknown

**ENVIRONMENTAL ASSESSMENT:**

Was an environmental assessment undertaken**?** 🗆 Yes 🗆 No 🗆 Unknown If Yes, Date commenced: ......../......../........

Details: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..…

**ADDITIONAL COMMENTS:**

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