

Case name: DOB:/...../..... Notification ID:
First name Surname

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:

Case name: *First name* *Surname* DOB:/...../..... Notification ID:

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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hospital: Ward:..... Admission date:/...../..... Discharge date:/...../.....
Resided in a residential care facility (including temporary or respite care)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility:
Shops and shopping complexes (cooling water systems)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Clubs, cinemas, hospitals (as a visitor), hotels, conference facilities (cooling water systems)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Pools/aquatic centres, spas (including home spas), water parks	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Water fountains or sprinklers (including overhead misting sprinkler systems)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Car/truck wash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Dental treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Humidifier, nebulisers or other respiratory devices	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other – consider CBD, industrial/building sites, sporting venues, aquariums, water misters	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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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)	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
	<input type="checkbox"/> Unknown			
Overseas	<input type="checkbox"/> Yes			
	<input type="checkbox"/> No			
	<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Washed hands routinely after gardening activities	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Use potting mix or landscaping materials	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Prior knowledge of risks from potting mix or landscaping materials	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Wore gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Wore mask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Watered hanging baskets	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Visited a plant nursery/gardening centre/landscaping centre	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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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:

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ADDITIONAL COMMENTS:

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