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

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

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

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	

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

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	

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

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:

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....
.....