

NATIONAL ENHANCED LEGIONELLA SURVEILLANCE ENGLAND AND WALES



May 2010

THE SCHEME IS COORDINATED BY:
Health Protection Agency, Centre for Infections

OBJECTIVES:

- To detect clusters or outbreaks of legionella infection in the UK or abroad through the national surveillance of all reported cases in residents of England and Wales
- To identify sources of infection so that control measures can be applied to prevent further cases
- To disseminate legionella surveillance information to all those who need to know

CfI USE ONLY:

CASE No. _____

CATEGORY: _____

REPORTED TO ELDSNet:

REGION: _____

REPORTER'S DETAILS:

Form completed by: _____

Date of report: _____

Telephone contact no: _____

Email address: _____

Name of relevant CCDC: _____

Reporting HPU: _____

PLEASE SUBMIT THIS FORM:

1. to your Regional Unit in accordance with your local protocol

2. copy to Centre for Infections (legionella@hpa.org.uk)

fax: 020 8200 7868 (For attention of: Legionella section)

tel: 020 8327 7056

For security, only email case details to and from an HPA email account

Legionnaires' disease is a notifiable disease. Fields **highlighted** are essential for the enhanced surveillance scheme, all other fields are statutory fields and **MUST** be completed; please ensure these are completed, where applicable, before the form is submitted.

Please indicate the type of case being reported: **LEGIONNAIRES' DISEASE** **PONTIAC FEVER**

Patient Details

| | | | | | | | |
|------------------|----|-----------|--|---------|--------------|-----------|--|
| Forename | | | | Surname | | | |
| Date of Birth | | Age | | Gender | | | |
| NHS Number | | | | | | | |
| Home Address | | | | | | | |
| | | | | | | | |
| Post Code | | Telephone | | Mobile | | | |
| Occupation | | | | | | | |
| Job description | | | | | | | |
| Work Address | | | | | | Post Code | |
| GP Name | Dr | | | | GP Telephone | | |
| Practice Name | | | | | | | |
| Practice Address | | | | | | | |

Clinical History

| | | | | | | | | |
|--|---------------|-----------------------------|---|--|-------------------|--------------------------|------------|--------------------------|
| Date of onset of symptoms | | Did patient have pneumonia? | | | | | | |
| Tick main clinical features (If 'other', please specify) | Chest pain: | <input type="checkbox"/> | Confusion: | <input type="checkbox"/> | Cough: | <input type="checkbox"/> | Diarrhoea: | <input type="checkbox"/> |
| | Lethargy: | <input type="checkbox"/> | Shortness of breath: | <input type="checkbox"/> | Other: | | | |
| Was the patient immunosuppressed? (If 'other', please specify) | Chemotherapy: | <input type="checkbox"/> | Long term steroids: | <input type="checkbox"/> | Organ transplant: | | | |
| | Splenectomy: | <input type="checkbox"/> | Other: | | | | | |
| Give details of any underlying condition (e.g. diabetes, liver disease, heart disease, COPD, | | | | | | | | |
| Was the patient hospitalised? | | | | | | | | |
| Hospital of admission | | | | Date of admission (dd/mm/yyyy) | | | | |
| Was the patient admitted to a critical care facility? | | | Did the patient require invasive ventilation (intubation and mechanical ventilation)? | | | | | |
| Ward: | | | Consultant: | | | | | |

Patient Status

| | |
|--|---------------------------|
| Current status (Dead / Still ill / Recovered) | (If dead date of death:) |
|--|---------------------------|

Please do **NOT** wait for the 30 day time period to be over before submitting the form to Cfl. The form **MUST** be submitted as soon as possible with a response to the next question submitted as an update at the appropriate time.

| | |
|---|----------------------------|
| 30 day status (Dead / Still ill / Recovered) | (If dead, date of death:) |
|---|----------------------------|

Patient's Two Week Diary

Activities in the two weeks prior to onset

| | |
|----------------------------|--|
| Means of regular transport | |
| Route to work | |
| Usual places of shopping | |

Was the patient exposed (in the UK or abroad) to:

| Exposure | Yes/No | Details (e.g. name, location, postcode etc) | Exposure | Yes/No | Details (e.g. name, location, postcode etc) |
|-------------------------|--------|---|--|--------|---|
| Whirlpool spas/ Hot tub | | | Air conditioning | | |
| Showers | | | Water displays in shopping or garden centre. | | |
| Fountains | | | Food displays with water mists | | |
| Car washes | | | Other 1: | | |
| Jet washes | | | Other 2: | | |

| | |
|--|--|
| Any recent repairs on property/garden (e.g. plumbing, ponds/pools) | |
|--|--|

| | |
|--------------------------------|--|
| Any other relevant information | |
|--------------------------------|--|

IF THE CASE HAS TRAVELLED EITHER WITHIN THE UK OR ABROAD DURING THE INCUBATION PERIOD, OR VISITED A HOSPITAL, PLEASE COMPLETE APPROPRIATE SECTIONS ON PAGE 4.

PLACES VISITED, ROUTES AND JOURNEYS (e.g. hotels, leisure centres, garden centres, dentists)
WHERE POSSIBLE PLEASE INCLUDE POSTCODE

| | MORNING | AFTERNOON | EVENING |
|----------|--------------------|-----------|---------|
| Day - 1 | (DAY BEFORE ONSET) | | |
| Day - 2 | | | |
| Day - 3 | | | |
| Day - 4 | | | |
| Day - 5 | | | |
| Day - 6 | | | |
| Day - 7 | | | |
| Day - 8 | | | |
| Day - 9 | | | |
| Day - 10 | | | |
| Day - 11 | | | |
| Day - 12 | | | |
| Day - 13 | | | |
| Day - 14 | | | |

Risk Factor Information

Cases are defined as hospital or travel-associated if they fulfil the criteria below

Definitions

Hospital associated cases: Patients who spent at least one night in hospital during the ten days prior to onset of symptoms.

Travel associated cases: One or more overnight stays in holiday accommodation in the UK or abroad in the 2-10 days before onset of illness.

Possible Hospital Associated Case

| | | |
|--|----------------|--------------|
| Was the patient <u>admitted</u> to hospital at any time in the ten days BEFORE onset? | | |
| Hospital of admission | | Ward or Unit |
| Date of admission (dd/mm/yyyy) | | |
| If the patient was transferred from another hospital within the incubation period, please give details: | | |
| Hospital prior to transfer | Dates of stay: | to |
| Did the patient <u>visit</u> a hospital at any time in the two weeks BEFORE onset? (e.g. outpatient appointments, visiting another patient) | | |
| Details (including dates) | | |

Possible Travel Associated Case

ABROAD

| Did the patient <u>travel abroad</u> in the two to ten days before onset? | | | | | |
|---|-----------------------------|----------------|------------------------------|---------|---------|
| Arrival Date (dd/mm/yyyy) | Departure Date (dd/mm/yyyy) | Town or Resort | Hotel or other Accommodation | Room No | Country |
| | | | | | |
| | | | | | |
| | | | | | |
| Tour Operator (if known) | | | | | |

UNITED KINGDOM

| Did the patient <u>travel within the UK</u> in the two to ten days before onset? | | | | |
|--|-----------------------------|----------------|------------------------------|---------|
| Arrival Date (dd/mm/yyyy) | Departure Date (dd/mm/yyyy) | Town or Resort | Hotel or other Accommodation | Room No |
| | | | | |
| | | | | |
| | | | | |
| Tour Operator (if known) | | | | |

| |
|--|
| Additional information: |
| |

Microbiology Results

AT LEAST ONE OF THESE TESTS MUST HAVE A POSITIVE RESULT

L.PNEUMOPHILA RESPIRATORY CULTURE (i.e. Sputum)

| Date of specimen (dd/mm/yyyy) | Specimen | Species | Serogroup | Result* (Positive / Negative / Equivocal) |
|----------------------------------|----------|---------|-----------|---|
| | | | | |
| | | | | |

L.PNEUMOPHILA URINARY ANTIGEN DETECTION

| Date of specimen (dd/mm/yyyy) | Manufacturer and Kit used | Result* (Positive / Negative / Equivocal) |
|----------------------------------|---------------------------|---|
| | | |

L.PNEUMOPHILA SEROLOGY

| Date of serum (dd/mm/yyyy) | Assay used (Name of Kit used) | Titre | Result* (Positive / Negative / Equivocal) |
|-------------------------------|----------------------------------|--|---|
| | | <64 <input type="checkbox"/> 1:64 <input type="checkbox"/> 1:128 <input type="checkbox"/> 1:256 <input type="checkbox"/> >512 <input type="checkbox"/> | |
| | | <64 <input type="checkbox"/> 1:64 <input type="checkbox"/> 1:128 <input type="checkbox"/> 1:256 <input type="checkbox"/> >512 <input type="checkbox"/> | |

L.PNEUMOPHILA PCR

| Date of specimen (dd/mm/yyyy) | Type of Specimen | Result (Positive / Negative / Equivocal) |
|----------------------------------|------------------|--|
| | | |

OTHER METHOD (Please specify)

| Date of specimen (dd/mm/yyyy) | Specimen | Species | Serogroup | Result* (Positive / Negative / Equivocal) |
|----------------------------------|----------|---------|-----------|---|
| | | | | |

Local laboratory where microbiology was tested:

SAMPLES FROM LEGIONELLA POSITIVE PATIENTS MUST BE SENT TO RSIL (REFERENCE LAB)

Environmental Investigations

Has sampling of water systems been requested? (Y/N/Unknown)
(see: www.hpa.org.uk/infections/topics_az/legionella/advice)

If yes, please specify the laboratory carrying out tests:

| Location of sampling, e.g. Patient's home, hospital, industrial/commercial etc | Additional comment e.g. domestic hot water tap, cooling tower on site | Result (Positive / Negative / Unknown) |
|---|--|---|
| | | |
| | | |
| | | |

PLEASE UPDATE THE NATIONAL SURVEILLANCE SCHEME WITH ANY OUTSTANDING OR ADDITIONAL ENVIRONMENTAL RESULTS.