State of California—Health and Human Services Agency

Local ID Number _____

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

LEGIONELLOSIS CASE REPORT

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	
			☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	*Apartment / Unit Number*

City / Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work / School Location	*Work / School Contact*

Gender
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male / transman ☐ Identity not listed ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 11)	*Other Describe/Specify*

Occupation (see list on page 11)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

Race(s)
(check all that apply, race descriptions on page 10)

The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 10)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 10)*
- ☐ Native Hawaiian
- ☐ Fijian
- ☐ Guamanian
- ☐ Samoan
- ☐ Tongan
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

First three letters of patient's last name: | | | |

CLINICAL INFORMATION

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown	*Onset Date (mm/dd/yyyy)*	*Date First Sought Medical Care (mm/dd/yyyy)*

Symptoms (check all that apply)

☐ Cough ☐ Shortness of breath ☐ Fever ☐ Myalgia ☐ Other (specify): _____

☐ Headache ☐ Diarrhea ☐ Nausea ☐ Confusion

UNDERLYING CAUSES OR PRIOR ILLNESS

Condition	Yes	No	Unk	Comments
Asthma				
Chronic heart disease (i.e., coronary artery disease or heart failure, but not hypertension)				
Chronic liver disease				
Chronic kidney disease				
Chronic obstructive pulmonary disease (COPD)				
Current cancer (solid or hematologic)				
Diabetes mellitus				
Immunosuppression due to disease (e.g., rheumatologic, transplant, etc.)				*Please do NOT disclose or specify HIV/AIDS information on this form.*
Immunosuppression due to medication				
Neurologic disease (e.g., dementia, stroke, etc.)				
Current smoking				
Current vaping				
Drink alcohol				*How many servings of alcohol in a typical week?*
Other				*Specify*

***** THE HOSPITALIZATION INFORMATION REQUESTED BELOW SHOULD REFLECT HEALTH CARE RECEIVED DUE TO LEGIONELLOSIS. *****

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unknown	*Was patient hospitalized?* ☐ Yes ☐ No ☐ Unknown	*If Yes, how many total hospital nights?*

If there were any ER visits or hospital stays related to this illness, specify details below.

HOSPITALIZATION – DETAILS

Hospital Name 1	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*
Hospital Name 2	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*

First three letters of patient's last name: | | | |

HOSPITAL COURSE

Was patient admitted to the intensive care unit (ICU)? ☐ Yes ☐ No ☐ Unknown	*Was patient placed on invasive mechanical ventilation (i.e., intubated)?* ☐ Yes ☐ No ☐ Unknown

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unknown	*If Survived, Survived as of* _____ *(mm/dd/yyyy)*	*Date of Death (mm/dd/yyyy)*

LABORATORY INFORMATION

CLINICAL LABORATORY RESULTS SUMMARY

Specimen Type 1
☐ Urine
☐ Respiratory (lower respiratory samples, e.g., sputum, bronchoalveolar lavage, lung tissue, or pleural fluid)
☐ Blood
☐ Serum (acute)
☐ Other (specify): _____

NOTE: *Serology tests for legionella are only confirmatory if a fourfold or greater rise in antibody titer is measured between acute and convalescent specimens. Investigators are not expected to follow up on single acute serology results.*

Collection Date (mm/dd/yyyy)

Type of Test
☐ Antigen ☐ Culture ☐ PCR ☐ DFA ☐ IFA ☐ IHC ☐ Other (specify): _____

Result

Interpretation
☐ Positive ☐ Negative ☐ Equivocal

Legionella Species
☐ *Legionella pneumophila* ☐ *Legionella longbeachae* ☐ *Legionella micdadei*
☐ *Legionella bozemanii* ☐ Other (specify): _____

Serogroup	*Laboratory Name*	*Telephone*

Specimen Type 2
☐ Urine
☐ Respiratory (lower respiratory samples, e.g., sputum, bronchoalveolar lavage, lung tissue, or pleural fluid)
☐ Blood
☐ Serum (acute)
☐ Serum (convalescent)
☐ Other (specify): _____

NOTE: *Serology tests for legionella are only confirmatory if a fourfold or greater rise in antibody titer is measured between acute and convalescent specimens. Investigators are not expected to follow up on single acute serology results.*

Collection Date (mm/dd/yyyy)

Type of Test
☐ Antigen ☐ Culture ☐ PCR ☐ DFA ☐ IFA ☐ IHC ☐ Other (specify): _____

Result

Interpretation
☐ Positive ☐ Negative ☐ Equivocal

Legionella Species
☐ *Legionella pneumophila* ☐ *Legionella longbeachae* ☐ *Legionella micdadei*
☐ *Legionella bozemanii* ☐ Other (specify): _____

Serogroup	*Laboratory Name*	*Telephone*

IMAGING SUMMARY

Imaging 1

Type of Imaging
☐ Chest x-ray ☐ Chest CT ☐ Other (specify):_____

Imaging Date (mm/dd/yyyy)

Findings

Impression

Hospital or Clinic Name

Telephone

Imaging 2

Type of Imaging
☐ Chest x-ray ☐ Chest CT ☐ Other (specify):_____

Imaging Date (mm/dd/yyyy)

Findings

Impression

Hospital or Clinic Name

Telephone

First three letters of patient's last name: | | | |

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD IS 14 DAYS PRIOR TO ILLNESS ONSET

HEALTHCARE EXPOSURES / RISK FACTORS

Did the patient visit or stay in a healthcare setting (e.g., hospital, outpatient clinic, dialysis or oncology center, long term care/rehab/skilled nursing facility, etc.) during the incubation period? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify details of all healthcare exposures below.*

HEALTHCARE EXPOSURES / RISK FACTORS – DETAILS

Facility Name 1	*Street Address*	*City*	*State*	*Zip Code*
	Type of Healthcare Setting/Facility ☐ Hospital (emergency room, inpatient ward, etc.) ☐ Unknown ☐ Clinic (e.g., dental or outpatient office, dialysis or oncology center, etc.) ☐ Other (specify): _____ ☐ Long term care (LTCF) or skilled nursing facility (SNF)			
	Type of Exposure ☐ Inpatient/Resident ☐ Outpatient ☐ Visitor/Volunteer ☐ Employee ☐ Unknown ☐ Other (specify): _____			
	Visit Start Date (mm/dd/yyyy)	*Visit End Date (mm/dd/yyyy)*		
	Invasive Mechanical Ventilation (i.e., intubation) ☐ Yes ☐ No ☐ Unknown	*Other Respiratory Equipment (e.g. BIPAP, CPAP, nebulizer, etc.)* ☐ Yes ☐ No ☐ Unknown		
	Healthcare Exposure Notes (e.g., details regarding water exposures, etc.)			

Facility Name 2	*Street Address*	*City*	*State*	*Zip Code*
	Type of Healthcare Setting/Facility ☐ Hospital (emergency room, inpatient ward, etc.) ☐ Unknown ☐ Clinic (e.g., dental or outpatient office, dialysis or oncology center, etc.) ☐ Other (specify): _____ ☐ Long term care (LTCF) or skilled nursing facility (SNF)			
	Type of Exposure ☐ Inpatient/Resident ☐ Outpatient ☐ Visitor/Volunteer ☐ Employee ☐ Unknown ☐ Other (specify): _____			
	Visit Start Date (mm/dd/yyyy)	*Visit End Date (mm/dd/yyyy)*		
	Invasive Mechanical Ventilation (i.e., intubation) ☐ Yes ☐ No ☐ Unknown	*Other Respiratory Equipment (e.g. BIPAP, CPAP, nebulizer, etc.)* ☐ Yes ☐ No ☐ Unknown		
	Healthcare Exposure Notes (e.g., details regarding water exposures, etc.)			

TRAVEL HISTORY

Did patient travel outside county of residence during the incubation period (e.g., work commute, day trips, etc.)? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify all locations and dates below.*

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started *(mm/dd/yyyy)*	Date Travel Ended *(mm/dd/yyyy)*
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					
☐ Domestic ☐ Unknown ☐ International					

First three letters of patient's last name: | | | |

TRAVEL ACCOMMODATIONS

Did patient spend any nights away from home (excluding healthcare settings) during the incubation period?
☐ Yes ☐ No ☐ Unknown

If Yes, specify all locations and dates below.

TRAVEL ACCOMMODATIONS – DETAILS

Accommodation Name 1 (e.g., hotel, cruise ship, Airbnb/VRBO, friend's house, motorhome/trailer, etc.)

Street Address		*City*	*State*	*Zip Code*
Country	*Room Number*	*Arrival Date (mm/dd/yyyy)*	*Departure Date (mm/dd/yyyy)*	
Accommodation Notes (e.g., name and contact information for private property owner, details regarding water exposures, etc.)				

Accommodation Name 2 (e.g., hotel, cruise ship, Airbnb/VRBO, friend's house, motorhome/trailer, etc.)

Street Address		*City*	*State*	*Zip Code*
Country	*Room Number*	*Arrival Date (mm/dd/yyyy)*	*Departure Date (mm/dd/yyyy)*	
Accommodation Notes (e.g., name and contact information for private property owner, details regarding water exposures, etc.)				

RESIDENTIAL EXPOSURES / RISK FACTORS

In what type of residence does the patient live?
☐ Single-family residence (e.g., house, mobile home, etc.)
☐ Multi-family residence (e.g., apartment, condominium, dormitories, other group living, etc.)
☐ Assisted living facility
☐ Senior living facility
☐ Correctional facility
☐ Homeless (e.g., shelter, in car/vehicle, unsheltered, couch surfing, other, etc.)
☐ Unknown
☐ Other (specify): _____

If assisted living, senior living, correctional facility, or homeless shelter, specify below.

Name of Facility		
Start Date (mm/dd/yyyy)	*End Date (mm/dd/yyyy)*	
Street Address		
City	*State*	*Zip Code*

OCCUPATIONAL EXPOSURES / RISK FACTORS

Did the patient work during the incubation period?
☐ Yes ☐ No ☐ Unknown

If Yes, specify location below.

Occupation/Job Description	*Company Name*	
Street Address		
City	*State*	*Zip Code*
Notes		

COMMUNITY EXPOSURES / RISK FACTORS

Did the patient spend any time at a location other than home or work during the incubation period?
☐ Yes ☐ No ☐ Unknown

If Yes, specify location below.

Name of Facility or Place		
Street Address		
City	*State*	*Zip Code*
Notes		

First three letters of patient's last name: | | | |

DID THE PATIENT VISIT ANY OF THE FOLLOWING DURING THE INCUBATION PERIOD?

Community Exposure	Yes	No	Unk	If Yes, specify			
Amusement park				*Name*			
				Street Address	*City*	*State*	*Zip Code*
				Notes			
Casino				*Name*			
				Street Address	*City*	*State*	*Zip Code*
				Notes			
Conference or convention				*Name*			
				Street Address	*City*	*State*	*Zip Code*
				Notes			
Day spa or resort				*Name*			
				Street Address	*City*	*State*	*Zip Code*
				Notes			
Gym				*Name*			
				Street Address	*City*	*State*	*Zip Code*
				Notes			
Golf course				*Name*			
				Street Address	*City*	*State*	*Zip Code*
				Notes			
Grocery store				*Name*			
				Street Address	*City*	*State*	*Zip Code*
				Notes			

First three letters of patient's last name: | | | |

WATER EXPOSURES / RISK FACTORS

DID THE PATIENT USE OR GO NEAR ANY OF THE FOLLOWING DURING THE INCUBATION PERIOD?

Water Exposure	Yes	No	Unk	If Yes, specify			
Spa/Hot tub/Whirlpool				*Street Address*	*City*	*State*	*Zip Code*
				Notes			
Misters (e.g., outdoor patio or grocery produce area, etc.)				*Street Address*	*City*	*State*	*Zip Code*
				Notes			
Decorative fountains				*Street Address*	*City*	*State*	*Zip Code*
				Notes			
Room humidifiers				*Street Address*	*City*	*State*	*Zip Code*
				Notes			
Other water-related exposure (e.g., steam rooms, sprinklers, swamp coolers, car washes, handheld showers, ice machines, etc.)				*Street Address*	*City*	*State*	*Zip Code*
				Notes			

Did the patient use any respiratory therapy equipment (e.g., nebulizer, CPAP, BIPAP, etc.) during the incubation period?
☐ Yes ☐ No ☐ Unknown

If Yes, specify below.

Does the device use a humidifier?
☐ Yes ☐ No ☐ Unknown

If the device uses a humidifier, what type of water is used in the device?
☐ Sterile ☐ Distilled ☐ Bottled ☐ Tap ☐ Unknown ☐ Other (specify): _____

Did the patient garden or use any potting soil during the incubation period?
☐ Yes ☐ No ☐ Unknown

CONTACTS/OTHER ILL PERSONS

Any contacts with similar illness?
☐ Yes ☐ No ☐ Unknown

If Yes, specify details below.

ILL CONTACTS - DETAILS

Name 1	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Illness Onset Date (mm/dd/yyyy)*
	Street Address			*Exposure Dates Shared with Index Case (mm/dd/yyyy)*	
	City		*State* *Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	
Name 2	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Illness Onset Date (mm/dd/yyyy)*
	Street Address			*Exposure Dates Shared with Index Case (mm/dd/yyyy)*	
	City		*State* *Zip Code*	*Date First Reported to Public Health (mm/dd/yyyy)*	

First three letters of patient's last name: | | | |

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date Form Completed (mm/dd/yyyy)

First Reported By	Health education provided?	Patient restriction / clearance needed?
☐ Clinician ☐ Laboratory ☐ Other (specify): _____	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case?	Contact Name / Case Number
☐ Yes ☐ No ☐ Unknown	

DISEASE CASE CLASSIFICATION

Disease Type

☐ Legionnaires' disease (illness with pneumonia) ☐ Extrapulmonary legionellosis (*Legionella* infection present at site outside of the lungs)

☐ Pontiac fever (illness without pneumonia)

OUTBREAK

Part of known outbreak?	If Yes, extent of outbreak:
☐ Yes ☐ No ☐ Unknown	☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other:_____

Mode of Transmission	Vehicle of Outbreak	Pattern 1 ID number	Pattern 2 ID number
☐ Point source ☐ Person-to-person ☐ Unknown ☐ Other:_____			

ENVIRONMENTAL ASSESSMENT (OPTIONAL)

Were environmental assessment or other follow-up activities performed at any of patient's exposure sites?

☐ Yes ☐ No ☐ Unknown

If Yes, specify name and location of facility, and check all boxes that apply.

Name of Facility	Date of Visit (mm/dd/yyyy)		
Street Address	**City**	**State**	**Zip Code**

Environmental Assessment and Follow-Up Activities

☐ Conducted retrospective/prospective surveillance for additional cases

☐ Completed CDC *Legionella* Environmental Assessment Form (LEAF)

☐ Collected/sent water samples for *Legionella* testing

☐ Collected water samples for general chemistry testing

☐ Performed disinfection of water system(s) (e.g., hyperchlorination, superheating, etc.)

☐ Performed flushing of water system(s)

☐ Installed devices to mitigate water aerosolization

☐ Installed supplemental disinfection system

☐ Implemented restrictions on water use

☐ Reviewed and/or developed water management plan (WMP)

☐ Disseminated provider alerts and/or public notifications

☐ Sent environmental isolates to public health laboratory for sequencing

☐ Other (specify): _____

Environmental Assessment Notes

First three letters of patient's last name: | | | |

STATE USE ONLY

State Case Classification (see case definition on page 9)
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Need additional information

Exposure Classification
☐ Community-Associated ☐ Healthcare-Associated
☐ Travel-Associated ☐ Sporadic

CDPH HAI Program Case Classification
☐ Presumptive healthcare-associated ☐ Not healthcare-associated
☐ Possible healthcare-associated ☐ Other (specify):_____

If case was Travel-Associated, was case reported to CDC at travellegionella@cdc.gov or to California local health jurisdiction(s)?
☐ Yes ☐ No ☐ Unknown

CDPH MICROBIAL DISEASES LABORATORY (MDL) OR OTHER REFERENCE PUBLIC HEALTH LABORATORY (PHL) RESULTS (OPTIONAL)

Was whole genome sequencing (WGS) completed on clinical or environmental isolates?
☐ Yes ☐ No ☐ Unknown

If Yes, specify results for each separate isolate below and upload to electronic filing cabinet.

CDPH MICROBIAL DISEASES LABORATORY (MDL) OR OTHER REFERENCE PUBLIC HEALTH LABORATORY (PHL) RESULTS – DETAILS (OPTIONAL)

Accession Number or Specimen ID 1		*Clinical or environmental isolate?* ☐ Clinical ☐ Environmental	
Submitting Laboratory		*Testing Laboratory*	
Sequence Type (MLST)	*Serogroup*	*Was sequence data uploaded to a public database (e.g., NCBI)?* ☐ Yes ☐ No ☐ Unknown	*Did isolate cluster with other clinical or environmental isolate(s)?* ☐ Yes ☐ No ☐ Unknown
Accession Number or Specimen ID 2		*Clinical or environmental isolate?* ☐ Clinical ☐ Environmental	
Submitting Laboratory		*Testing Laboratory*	
Sequence Type (MLST)	*Serogroup*	*Was sequence data uploaded to a public database (e.g., NCBI)?* ☐ Yes ☐ No ☐ Unknown	*Did isolate cluster with other clinical or environmental isolate(s)?* ☐ Yes ☐ No ☐ Unknown

CASE DEFINTION

LEGIONELLOSIS (2020)

CLINICAL CRITERIA

Legionellosis is associated with three clinically and epidemiologically distinct illnesses: Legionnaires' disease, Pontiac fever, or extrapulmonary legionellosis.

- **Legionnaires' disease (LD):** LD presents as pneumonia, diagnosed clinically and/or radiographically. Evidence of clinically compatible disease can be determined several ways: a) a clinical or radiographic diagnosis of pneumonia in the medical record OR b) if "pneumonia" is not recorded explicitly, a description of clinical symptoms that are consistent with a diagnosis of pneumonia.
- **Pontiac fever (PF):** PF is a milder illness. While symptoms of PF could appear similar to those described for LD, there are distinguishing clinical features. PF does not present as pneumonia. It is less severe than LD, rarely requiring hospitalization. PF is self-limited, meaning it resolves without antibiotic treatment.
- **Extrapulmonary legionellosis (XPL):** *Legionella* can cause disease at sites outside the lungs (for example, associated with endocarditis, wound infection, joint infection, graft infection). A diagnosis of extrapulmonary legionellosis is made when there is clinical evidence of disease at an extrapulmonary site and diagnostic testing indicates evidence of *Legionella* at that site.

LABORATORY CRITERIA

Confirmatory laboratory evidence:
- Isolation of any *Legionella* organism from lower respiratory secretions, lung tissue, pleural fluid, or extrapulmonary site.
- Detection of any *Legionella* species from lower respiratory secretions, lung tissue, pleural fluid, or extrapulmonary site by a validated nucleic acid amplification test.
- Detection of *Legionella pneumophila* serogroup 1 antigen in urine using validated reagents.
- Fourfold or greater rise in specific serum antibody titer to *Legionella pneumophila* serogroup 1 using validated reagents.

Presumptive laboratory evidence: None required for case classification.

Supportive laboratory evidence:
- Fourfold or greater rise in antibody titer to specific species or serogroups of *Legionella* other than *L. pneumophila* serogroup 1 (e.g., *L. micdadei*, *L. pneumophila* serogroup 6).
- Fourfold or greater rise in antibody titer to multiple species of *Legionella* using pooled antigens.
- Detection of specific *Legionella* antigen or staining of the organism in lower respiratory secretions, lung tissue, pleural fluid, or extrapulmonary site associated with clinical disease by direct fluorescent antibody (DFA) staining, immunohistochemistry (IHC), or other similar method, using validated reagents.

EPIDEMIOLOGIC LINKAGE

1) Epidemiologic link to a setting with a confirmed source of *Legionella* (e.g., positive environmental sampling result associated with a cruise ship, public accommodation, cooling tower, etc.); OR
2) Epidemiologic link to a setting with a suspected source of *Legionella* that is associated with at least one confirmed case.

CASE CLASSIFICATIONS

- **Confirmed Legionnaires' disease (LD):** A clinically compatible case of LD with confirmatory laboratory evidence for *Legionella*.
- **Probable Legionnaires' disease (LD):** A clinically compatible case with an epidemiologic link during the 14 days before onset of symptoms**.**
- **Suspect Legionnaires' disease (LD):** A clinically compatible case of LD with supportive laboratory evidence for *Legionella*.
- **Confirmed Pontiac fever (PF):** A clinically compatible case of PF with confirmatory laboratory evidence for *Legionella*.
- **Probable Pontiac fever (PF):** A clinically compatible case with an epidemiologic link during the 3 days before onset of symptoms.
- **Suspect Pontiac fever (PF):** A clinically compatible case of PF with supportive laboratory evidence for *Legionella*.
- **Confirmed Extrapulmonary legionellosis (XPL):** A clinically compatible case of XPL with confirmatory laboratory evidence of *Legionella* at an extrapulmonary site.
- **Suspect Extrapulmonary legionellosis (XPL):** A clinically compatible case of XPL with supportive laboratory evidence of *Legionella* at an extrapulmonary site.

HEALTHCARE-ASSOCIATED CASE DEFINITIONS

- **Presumptive healthcare-associated Legionnaires' disease:** A case with ≥10 days of continuous stay at a healthcare facility during the 14 days before onset of symptoms.
- **Possible healthcare-associated Legionnaires' disease:** A case that spent a portion of the 14 days before date of symptom onset in one or more healthcare facilities, but does not meet the criteria for presumptive HA-LD.

TRAVEL-ASSOCIATED CASE DEFINITIONS

- **Travel-associated Legionnaires' disease**: A case of Legionnaires' disease in a patient who has a history of spending at least one night away from home (excluding healthcare settings) in the 14 days before onset of illness.
- **Travel-associated Pontiac fever**: A case of Pontiac fever in a patient who has a history of spending at least one night away from home (excluding healthcare settings) in the 3 days before onset of illness.

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Adult film actor/actress
- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - server
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - nurse
- Medical - other/unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent/guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Volunteer
- Other
- Refused
- Unknown