

NATIONAL SURVEILLANCE SCHEME FOR LEGIONNAIRES' DISEASE

November 2007

CENTRES RESPONSIBLE FOR LEGIONELLA SURVEILLANCE:

Health Protection Agency, Communicable Disease Surveillance Centre (Northern Ireland)

OBJECTIVES:

- To detect clusters of outbreaks of legionella infection in the UK or abroad through the national surveillance of all reported cases in residents of Northern Ireland
- 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.

Please return this form by fax or post to: Lisa Maguire
 Communicable Disease Surveillance Centre (Northern Ireland)
 McBrien Building
 Belfast City Hospital
 Lisburn Road
 Belfast
 BT9 7AB
 Tel: 02890 263422
 Fax: 02890 263532
 Email: lisa.maguire@hpa.org.uk

Personal Details

Name of patient:		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth:	__/__/__	Age:
NHS Hospital No:		
Home address:		
Postcode:		
Occupation:		
Work address:		
	Postcode:	

Clinical History of Case

Date of onset of symptoms of legionellosis	__/__/__
Did this patient have pneumonia?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What were the main clinical features?	
Has the patient had a recent organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/>
Was the patient immunosuppressed for other reasons? If Yes please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/>
Please give details of any other underlying condition:	
Hospital for patient admission:	
Date of admission:	__/__/__
Admitted to ITU:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Outcome: 1: Death <input type="checkbox"/> (date of death: __/__/__) 2: Still ill <input type="checkbox"/> 3: Recovered <input type="checkbox"/>	

Hospital Acquired Case

Was the patient in hospital for any time in the two weeks BEFORE the date of onset of symptoms of legionellosis: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hospital for patient admission:	
Diagnosis on admission:	Date of admission: ___/___/___
Type of ward or unit in which patient was resident:	
If patient was transferred from another hospital, please give details:	
Name of hospital before transfer:	
Dates of stay (from - to):	___/___/___ to ___/___/___

Possible Community Acquired Case

In the two weeks before onset of symptoms, did the patient use or spend time near a whirlpool/spa Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Yes, please specify:	

Possible Travel Associated Case

Did the patient spent any nights away from home (UK or abroad) in the two weeks before onset, please give details: Yes <input type="checkbox"/> No <input type="checkbox"/>					
Country	Town or Resort	Hotel/other accommodation (apartments/campsites/cruise ships etc)	Rm No.	Dates of stay	
				Arrival	Departure
Tour Operator (if known):					
Did the patient bathe in a whirlpool/spa? Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/>					
If Yes, please specify:					
Additional information:					

Additional Information

Please provide any additional information relevant to the case's possible source of exposure. e.g. day trips, work environment:

Case Definitions for Legionnaires' disease

I) Confirmed case

A clinical diagnosis of pneumonia with laboratory evidence of one or more of the following:

- Culture of *Legionella* spp from clinical specimens;
- Seroconversion (a four fold rise or greater) by the indirect immunofluorescent antibody test (IFAT) using *L. pneumophila* serogroup 1 antigen;
- Positive urine ELISA using validated reagents.

II) Presumptive case

A clinical diagnosis of pneumonia with laboratory evidence of one or more of the following:

- A single high titre using IFAT above;
- Positive direct fluorescence (DFA) on a clinical specimen using validated monoclonal antibodies;
- Seroconversion (a four fold rise or greater) by the indirect immunofluorescent antibody test (IFAT) to *L. pneumophila* other serogroups or other legionella species.

Legionella Microbiology Results

PLEASE ENSURE ALL POSITIVE SAMPLES ARE SENT TO RSIL

A: Culture: Done Not done

	Date	Specimen	Species	Serogroup	Result *	
					Positive	Negative
1					<input type="checkbox"/>	<input type="checkbox"/>
2					<input type="checkbox"/>	<input type="checkbox"/>

* If positive, was the isolate referred to RSIL? Yes No

B: Urine Antigen detection: Done Not done

Date	Manufacturer & Kit used	Result *	
		Positive	Negative
		<input type="checkbox"/>	<input type="checkbox"/>

* If positive, was the urine referred to RSIL? Yes No

C: Serology: Done Not done

Date	Titre	Assay used (Manufacturer & Kit used)	Result *	
			Positive	Negative
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

* If positive, was the sera referred to RSIL Yes No

Has this result been confirmed in the presence of campylobacter blocking fluid? Yes No Not Sure

D: Other Method: (Specify)

Date	Specimen	Result		
		Positive	Negative	Equivocal
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Laboratory Details

Laboratory where microbiology carried out:	
Laboratory confirmation at HPA, CFI, RSIL, Colindale?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Confirmation at another laboratory?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, please specify:	

Environmental Investigations

Has sampling of water systems been requested (see: www.hpa.org.uk/infections/topics_az/legionella/advice)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, please specify i.e. patients home, hospital, industrial/commercial, other:	Please give details:
Name and address of laboratory carrying out sampling:	
Results of sampling (if known):	Pos <input type="checkbox"/> Neg <input type="checkbox"/> Not Known <input type="checkbox"/>

Reporter's Details

Name of person reporting case to CDSC:	
Date of report:	___/___/___
Telephone contact number:	
Email address:	
Name of CCDC relevant to case:	
Name of HPU responsible for reporting case:	

Signature: Date: