

National Enhanced Legionella Surveillance Scotland

November 2014

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 Scotland.
- 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.

Reporter's details

Form completed by	<input type="text"/>
Job title	<input type="text"/>
Telephone contact no	<input type="text"/>
Email address	<input type="text"/>
Date of report	<input type="text" value="DDMMYY"/>
NHS board	<input type="text"/>

Please submit this form to:

Dr Syed Ahmed
Health Protection Scotland,
Meridian Court, 5 Cadogan Street
Glasgow G2 6QE

Secure fax: 0141 300 1172

For security, only email case details
to and from an nhs.net account

Legionnaires' disease is a notifiable disease. Fields **highlighted** are essential for the enhanced surveillance scheme. All other fields are optional for HPS surveillance but full completion may inform your investigation.

Type of case: Legionnaires' disease ☐ Pontiac Fever ☐ Asymptomatic legionella infection ☐

I. Patient Details

Forename	<input type="text"/>	Surname	<input type="text"/>
Date of birth	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Age	<input type="text"/>
Gender (M/F)	<input type="text"/>		
CHI Number	<input type="text"/>		
Home Address	<input type="text"/>		
Postcode	<input type="text"/>	Tel no	<input type="text"/>
Mob no	<input type="text"/>		
Occupation	<input type="text"/>	Job description	<input type="text"/>
Work address	<input type="text"/>	Postcode	<input type="text"/>
GP name	<input type="text"/>	GP telephone no	<input type="text"/>
Practice name	<input type="text"/>		
Practice address	<input type="text"/>		

2. Clinical History and Patient Status

Date of onset of symptoms	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	Did patient have pneumonia?	<input type="text"/>
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 <input type="text"/>	
Was the patient immunosuppressed? (If 'other', please specify)			
Chemotherapy <input type="checkbox"/>	Long term steroids <input type="checkbox"/>	Organ transplant <input type="checkbox"/>	Splenectomy <input type="checkbox"/>
Other <input type="text"/>			
Give details of any underlying medical condition (e.g. diabetes, liver disease, heart disease, COPD, other)			
<input type="text"/>			
Give details of any other factors (e.g. smoking)			
<input type="text"/>			

Was the patient hospitalised? Yes ☐ No ☐

If yes, hospital of admission (full name of hospital)

Date of admission

Was the patient admitted to a critical care facility? Yes ☐ No ☐

Did the patient require invasive ventilation (intubation and mechanical ventilation)? Yes ☐ No ☐

Ward

Consultant

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 Health Protection Scotland. 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

3. Microbiology Results

At least one of these tests must have a positive result.

Name of local laboratory where microbiology was tested

Culture (respiratory sample i.e. sputum)

Date of specimen	Specimen	Species	Serogroup	Result (Positive / Negative)
<input type="text"/> <input type="text"/> <input type="text"/>				
<input type="text"/> <input type="text"/> <input type="text"/>				

Urinary Antigen detection

Date of specimen	Manufacturer and Kit used	Result (Positive / Negative / Equivocal)
<input type="text"/> <input type="text"/> <input type="text"/>		

Serology

Date of specimen	Assay used (Name of Kit used)	Titre	Result (Positive / Negative)
<input type="text"/> <input type="text"/> <input type="text"/>		<64 <input type="checkbox"/> 1:64 <input type="checkbox"/> 1:128 <input type="checkbox"/> 1:256 <input type="checkbox"/> >512 <input type="checkbox"/>	
<input type="text"/> <input type="text"/> <input type="text"/>		<64 <input type="checkbox"/> 1:64 <input type="checkbox"/> 1:128 <input type="checkbox"/> 1:256 <input type="checkbox"/> >512 <input type="checkbox"/>	

Polymerase Chain Reaction (PCR)

Date of specimen	Type of specimen	Result (Positive / Negative)
DD/MM/YY		
DD/MM/YY		

Other method (please specify)

Date of specimen	Specimen	Species	Serogroup	Result (Positive / Negative)
DD/MM/YY				
DD/MM/YY				

4. Source of Infection

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 two to fourteen days before onset of illness.

Was there a suspected source of infection identified for this individual?

Yes ☐

No ☐

If yes, was it suspected to be:

Travel related ☐

Hospital acquired ☐

Community acquired ☐

Any potentially associated others who are ill?

Yes ☐

No ☐

Not known ☐

4a. Possible Hospital Associated Case

Was the patient admitted to hospital at any time in the two weeks before onset?

Yes ☐

No ☐

Hospital of admission

Ward or Unit

Date of admission

Date of discharge

If the patient was transferred from another hospital within the incubation period, please give details

Name of hospital prior to transfer

Dates of stay

to

Did the patient visit a hospital at any time in the two weeks **before** onset (e.g. outpatient appointments, visiting another patient)?

Details (including dates)?

4b. Possible Travel Associated Case

Did the patient **travel away from home** in the two weeks before onset?

Yes ☐

No ☐

Arrival Date	Departure Date	Town or Resort	Hotel or other accommodation	Room No	Country
DD/MM/YY	DD/MM/YY				
DD/MM/YY	DD/MM/YY				
DD/MM/YY	DD/MM/YY				

Tour Operator (if known)?

Additional information

5. Patient's Two Week Diary

Activities in the two weeks prior to onset?

Means of regular transport

Route to work

Does your workplace have a cooling tower or evaporative condenser? Yes ☐ No ☐ Not known ☐

Usual places of shopping

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

Any other relevant information (e.g. occupational, healthcare)?

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

Type of exposure	Yes/No	Details (e.g. name, location, postcode, date etc)
Whirlpool spas/ Hot tub	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Showers	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Fountains	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Car washes	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Jet washes	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Air conditioning	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Water displays in shopping or garden centre.	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Food displays with water mists	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Car windscreen fluid without screenwash	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Garden sprinklers, pressure hoses	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Respiratory equipment (e.g. nebulisers)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dental equipment	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Gardening - potting soil	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Workplace irrigation system	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other 1	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other 2	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Places visited, routes and journeys e.g. hotels, leisure centres, garden centres, dentists, where possible please include postcode.

Day	Morning	Afternoon	Evening
Day 1	(day before onset)		
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

Day	Morning	Afternoon	Evening
Day 8			
Day 9			
Day 10			
Day 11			
Day 12			
Day 13			
Day 14			

6. Environmental Investigations

Has sampling of water systems been requested?

Yes ☐ No ☐ Not known ☐

(For further information please see: <http://www.hps.scot.nhs.uk/resp/publicationsdetail.aspx?id=61062>)

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)	Result (Positive / Negative / Unknown)

Please update the national surveillance scheme with any outstanding or additional environmental results.

This section contains specific questions about gardening and potting exposures

Have any gardening or outdoor exposures been undertaken in the two weeks before illness?

Yes ☐ No ☐

If **yes**, then please answer the following questions.

Possible water exposures in the garden:

Do you have an outside tap to use in your garden?

Yes ☐ No ☐

Frequency of use in two weeks before illness:

Never ☐ Once per week ☐ 2-4 times per week ☐ Every day ☐

When is the last time you used it?

Do you use garden hoses?

Yes ☐ No ☐

Where are they stored when not in use?

Are they warmed by the sun during the day?

Yes ☐ No ☐

Frequency of use in two weeks before illness:

Never ☐ Once per week ☐ 2-4 times per week ☐ Every day ☐

When is the last time you used them?

Do you have an irrigation/sprinkler system?

Yes ☐ No ☐

Is it capable of creating a fine mist?

Yes ☐ No ☐

Is this outdoor or indoor/in-greenhouse/in-hut?

Frequency of use in two weeks before illness:

Never ☐ Once per week ☐ 2-4 times per week ☐ Every day ☐

When is the last time it was used?

What is the source of water for this system?

Do you collect rainwater in water butts?

Yes ☐ No ☐

Frequency of use in two weeks before illness:

Never ☐ Once per week ☐ 2-4 times per week ☐ Every day ☐

When is the last time you used water from the butts?

Are the butts in the sun during the day?

Yes ☐ No ☐

When is the last time the water butts were emptied and cleaned?

Do you have a pond in your garden? Yes ☐ No ☐

Is there a fountain or waterfall in this pond? Yes ☐ No ☐

Do you use high-pressure water in your garden or to wash your car? Yes ☐ No ☐

Frequency of use in two weeks before illness:

Never ☐ Once per week ☐ 2-4 times per week ☐ Every day ☐

Possible compost/soil improver exposures in the garden

Do you use bags of shop-bought growing media/compost? Yes ☐ No ☐

Frequency of use in two weeks before illness:

Never ☐ Once per week ☐ 2-4 times per week ☐ Every day ☐

Where are the bags stored?

What bags have you used in the last two weeks?

Please give brand and product name details

Please give place and date where bags were bought

Note for visiting EHO: Please retain packaging and contents if possible, otherwise photograph packaging, including barcode and remove sample for analysis

Have you used farm produced composted material/soil improver in the two weeks before illness?

Yes ☐ No ☐

Frequency of use in two weeks before illness:

Never ☐ Once per week ☐ 2-4 times per week ☐ Every day ☐

What volume/weight of product?

Please provide product name, date of purchase and supplier details

Have you used farm manure in the two weeks before illness?

Yes ☐

No ☐

How long has the manure been composting?

Please provide source details and date of purchase

Do you have a compost heap?

Yes ☐

No ☐

Is your compost heap in a closed container?

Yes ☐

No ☐

How often to you add material to your compost heap?

When is the last time you turned your compost heap?

When is the last time you used material from your compost heap in your garden?

Have you bought potted plants or seedlings recently?

Yes ☐

No ☐

What did you buy?

When and where did you buy them?

Possible infection pathways

When you are using growing media/compost to plant seeds, seedlings or re-pot, are you:

Outside? Yes ☐ No ☐

Inside in a greenhouse or hut? Yes ☐ No ☐

Inside the house? Yes ☐ No ☐

Do you wear gloves when using growing media/compost? Yes ☐ No ☐

Do you wear a mask when using growing media/compost? Yes ☐ No ☐

Do you smell the growing media/compost before you use it? Yes ☐ No ☐

Do you eat and/or drink and/or smoke where you are using growing media/compost? Yes ☐ No ☐

Do you have facilities where you can wash your hands with soap where you are using growing media? Yes ☐ No ☐

Do you always wash your hands after gardening and before eating / drinking? Yes ☐ No ☐

If you smoke, do you wash your hands after gardening and before smoking? Yes ☐ No ☐

Do you have hanging baskets? Yes ☐ No ☐

Where are the hanging baskets? Outside ☐ Greenhouse ☐

Do they drip when you water them? Yes ☐ No ☐

How often do you water them?

Have samples been taken from the garden? Yes ☐ No ☐ Not known ☐

Location of sampling	Additional comment	Result