

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

Local ID Number \_\_\_\_\_

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary  Final

## LEGIONELLOSIS CASE REPORT

PATIENT INFORMATION				
Last Name	First Name	Middle Name	Suffix	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____				
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		If Yes, Est. Delivery Date (mm/dd/yyyy)		
Medical Record Number		Patient's Parent / Guardian Name		
Occupation Setting (see list on page 10)		Other (Describe / Specify)		
Occupation (see list on page 10)		Other (Describe / Specify)		
*Comment: self-identity or self-reporting  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.				
CLINICAL INFORMATION				
SIGNS AND SYMPTOMS				
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Onset Date (mm/dd/yyyy)		Date First Sought Medical Care (mm/dd/yyyy)
Symptoms (check all that apply) <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Fever <input type="checkbox"/> Myalgia <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Headache <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Confusion				

First three letters of  
patient's last name:

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**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.)				
Immunosuppression due to medication				
Neurologic disease (e.g., dementia, stroke, etc.)				
Current smoking				
Current vaping				
Alcohol abuse disorder				
Other				Specify:

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

**HOSPITALIZATION**

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
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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

**HOSPITAL COURSE**

Was patient admitted to the intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient placed on invasive mechanical ventilation (i.e., intubated)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
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**OUTCOME**

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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First three letters of patient's last name: 

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**LABORATORY INFORMATION**

**CLINICAL LABORATORY RESULTS SUMMARY**

<p><i>Specimen Type 1</i></p> <input type="checkbox"/> Urine <input type="checkbox"/> Respiratory (lower respiratory samples, e.g., sputum, bronchoalveolar lavage, lung tissue, or pleural fluid) <input type="checkbox"/> Blood <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Other (specify): _____	<p><i>Collection Date (mm/dd/yyyy)</i></p> <hr/> <p><i>Type of Test</i></p> <input type="checkbox"/> Antigen <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> IFA <input type="checkbox"/> IHC <input type="checkbox"/> Other (specify): _____			
	<p><i>Result</i></p> <hr/> <p><i>Interpretation</i></p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal			
	<p><i>Legionella Species</i></p> <input type="checkbox"/> <i>Legionella pneumophila</i> <input type="checkbox"/> <i>Legionella longbeachae</i> <input type="checkbox"/> <i>Legionella micdadei</i> <input type="checkbox"/> <i>Legionella bozemanii</i> <input type="checkbox"/> <i>Legionella anisa</i> <input type="checkbox"/> Other (specify): _____			
<p><b>NOTE:</b> 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.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><i>Serogroup</i></td> <td style="width: 33%;"><i>Laboratory Name</i></td> <td style="width: 33%;"><i>Telephone</i></td> </tr> </table>	<i>Serogroup</i>	<i>Laboratory Name</i>	<i>Telephone</i>
<i>Serogroup</i>	<i>Laboratory Name</i>	<i>Telephone</i>		

<p><i>Specimen Type 2</i></p> <input type="checkbox"/> Urine <input type="checkbox"/> Respiratory (lower respiratory samples, e.g., sputum, bronchoalveolar lavage, lung tissue, or pleural fluid) <input type="checkbox"/> Blood <input type="checkbox"/> Serum (acute) <input type="checkbox"/> Serum (convalescent) <input type="checkbox"/> Other (specify): _____	<p><i>Collection Date (mm/dd/yyyy)</i></p> <hr/> <p><i>Type of Test</i></p> <input type="checkbox"/> Antigen <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> IFA <input type="checkbox"/> IHC <input type="checkbox"/> Other (specify): _____			
	<p><i>Result</i></p> <hr/> <p><i>Interpretation</i></p> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal			
	<p><i>Legionella Species</i></p> <input type="checkbox"/> <i>Legionella pneumophila</i> <input type="checkbox"/> <i>Legionella longbeachae</i> <input type="checkbox"/> <i>Legionella micdadei</i> <input type="checkbox"/> <i>Legionella bozemanii</i> <input type="checkbox"/> <i>Legionella anisa</i> <input type="checkbox"/> Other (specify): _____			
<p><b>NOTE:</b> 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.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><i>Serogroup</i></td> <td style="width: 33%;"><i>Laboratory Name</i></td> <td style="width: 33%;"><i>Telephone</i></td> </tr> </table>	<i>Serogroup</i>	<i>Laboratory Name</i>	<i>Telephone</i>
<i>Serogroup</i>	<i>Laboratory Name</i>	<i>Telephone</i>		

**IMAGING SUMMARY**

Imaging 1	<i>Type of Imaging</i>	<i>Date (mm/dd/yyyy)</i>
	<input type="checkbox"/> Chest x-ray <input type="checkbox"/> Chest CT <input type="checkbox"/> Other (specify): _____	
	<i>Findings</i>	
	<i>Impression</i>	
	<i>Hospital or Clinic Name</i>	<i>Telephone</i>

Imaging 2	<i>Type of Imaging</i>	<i>Date (mm/dd/yyyy)</i>
	<input type="checkbox"/> Chest x-ray <input type="checkbox"/> Chest CT <input type="checkbox"/> Other (specify): _____	
	<i>Findings</i>	
	<i>Impression</i>	
	<i>Hospital or Clinic Name</i>	<i>Telephone</i>



First three letters of patient's last name:

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**TRAVEL ACCOMMODATIONS**

Did patient spend any nights away from home (excluding healthcare settings) during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.
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**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? <input type="checkbox"/> Single-family residence (e.g., house, mobile home, etc.) <input type="checkbox"/> Multi-family residence (e.g., apartment, condominium, dormitories, other group living, etc.) <input type="checkbox"/> Assisted living facility <input type="checkbox"/> Senior living facility <input type="checkbox"/> Correctional facility <input type="checkbox"/> Homeless (shelter, in car/vehicle, unsheltered, couch surfing, other) <input type="checkbox"/> Unk <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	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 more than 10 hours per week at any location other than at home or at work during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify location below.		
Name of Facility			
Street Address			
City		State	Zip Code
Notes			

First three letters of patient's last name:

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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				

**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				

First three letters of  
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**WATER EXPOSURES / RISK FACTORS (continued)**

Did the patient use any respiratory therapy equipment (e.g., nebulizer, CPAP, BIPAP, etc.) during the incubation period?

Yes  No  Unk

If Yes, specify below.

Does the device use a humidifier?

Yes  No  Unk

If the device uses a humidifier, what type of water is used in the device?

Sterile  Distilled  Bottled  Tap  Unk  Other (specify): \_\_\_\_\_

Did the patient garden or use any potting soil during the incubation period?

Yes  No  Unk

**CONTACTS / OTHER ILL PERSONS**

Any contacts with similar illness?

Yes  No  Unk

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)	

**NOTES / REMARKS****REPORTING AGENCY**

Investigator Name	Local Health Jurisdiction	Telephone Number	Date Form Completed (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____	Health education provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Patient restriction / clearance needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

**EPIDEMIOLOGICAL LINKAGE**

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number
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**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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, extent of outbreak: <input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
Mode of Transmission <input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	Vehicle of Outbreak	Pattern 1 ID number	Pattern 2 ID number

First three letters of patient's last name:

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**ENVIRONMENTAL ASSESSMENT**

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

Yes  No  Unk

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*

- 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
- Conducted retrospective/prospective surveillance for additional cases
- 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*

**STATE USE ONLY**

<p><i>State Case Classification (see case definition on page 9)</i></p> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information	<p><i>Exposure Classification</i></p> <input type="checkbox"/> Community-Associated <input type="checkbox"/> Healthcare-Associated <input type="checkbox"/> Travel-Associated <input type="checkbox"/> Sporadic
<p><i>If case was healthcare-associated, was CDPH HAI Program notified?</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<p><i>CDPH HAI Program Case Classification</i></p> <input type="checkbox"/> Presumptive healthcare-associated <input type="checkbox"/> Not healthcare-associated <input type="checkbox"/> Possible healthcare-associated <input type="checkbox"/> Other (specify): _____
<p><i>If case was Travel-Associated, was case reported to CDC at <a href="mailto:travellegionella@cdc.gov">travellegionella@cdc.gov</a> or to California local health jurisdiction(s)?</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

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

<p><i>Was whole genome sequencing (WGS) completed on clinical or environmental isolates? If Yes, specify results for each separate isolate below and upload to electronic filing cabinet.</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<p><i>Clinical or environmental isolate?</i></p> <input type="checkbox"/> Clinical <input type="checkbox"/> Environmental	
<p><i>Accession Number or Specimen ID</i></p>		<p><i>Submitting Laboratory</i></p>	
<p><i>Sequence Type (MLST)</i></p>		<p><i>Testing Laboratory</i></p>	
<p><i>Serogroup</i></p>	<p><i>Was sequence data uploaded to a public database (e.g., NCBI)?</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<p><i>Did isolate cluster with other clinical or environmental isolate(s)?</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

## CASE DEFINITION

### 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.

<b>RACE DESCRIPTIONS</b>	
<b>Race</b>	<b>Description</b>
American Indian or Alaska Native	Patient has origins in <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> 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 <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
<b>OCCUPATION SETTING</b>	
<ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul>
<b>OCCUPATION</b>	
<ul style="list-style-type: none"> <li>• Adult film actor/actress</li> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - server</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul>	<ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - nurse</li> <li>• Medical - other/unknown</li> <li>• Military</li> <li>• Police officer</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Stay at home parent/guardian</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Volunteer</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul>