**QUESTIONNAIRE D’INVESTIGATION DE TOUS LES CAS DE LEGIONELLOSE**

**LEGIODOM : N° Cas** |\_\_\_\_\_\_| |\_\_\_\_\_| *(exemple : ARA-001)*

*(Région de domicile 3 lettres, numéro d’inclusion)*

**DO : Code d’anonymat** |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

**Identifiant ARS (**numéro SIVSS)**: |\_\_\_\_\_\_\_\_\_\_\_\_|**

**SIGNALEMENT**

**Réception du signalement à l’ARS** Date : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Personne(s) en charge du signal : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coordonnées du déclarant et/ou médecinayant pris en charge le patient :

(Nom, fonction, hôpital, service, adresse, téléphone, email........) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coordonnées du laboratoire :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO reçue : [ ] oui [ ] non Date de réception: |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

**1 PATIENT DETAILS**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| Age |\_\_\_\_| years Gender : [ ]  M [ ]  F

Home adress : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal code : |\_\_|\_\_|\_\_|\_\_|\_\_| City : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s or Contact Person’s information : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number : |\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_| and |\_\_\_|\_\_\_|\_\_\_|\_\_\_|\_\_\_|

Email : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician’s Information : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Si patient domicilié dans une autre région: *précisez la région* : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N° du département: |\_\_\_|

Date de contact avec cette ARS : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Coordonnées de la personne contactée: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nom de la (les) personne(s) ARS en charge de l’investigation du cas si différente de la personne contactée

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Cette 1ère page qui contient des données directement nominatives devra être détruite après finalisation des investigations.***

Cette page est à compléter à la fin de questionnaire si le cas remplit les critères d’inclusion de l’étude LEGIODOM

Les données saisies dans l’application dédiée à l’étude sont uniquement

les données des questions rédigées sur fond grisé

***Case defintion*** *: Any person aged 18 years and older presenting with a clinical and/or radiological diagnosis of pneumonia with a lower respiratory tract sample for which a Legionella PCR is positive or a clinical strain of Legionella is available, who is hospitalized and residing in hexagonal France between XX/MM 202X and XX/MM 202X, and who has stayed at least one day at home in the 14 days preceding the onset of symptoms.*

***Exclusion criteria*** *: Individuals residing in or staying in a social or medico-social establishment, or those who have been away from their home during the 14 days preceding the onset of symptoms, will be excluded.*

**Inclusion criteria for the LEGIODOM study**

Radiologically confirmed pneumonia [ ]  yes [ ]  no

Clinical signs [ ]  yes [ ]  no

Isolation of clinical strain [ ]  yes [ ]  no

PCR positive clinical sample [ ]  yes [ ]  no

At least one day at home in hexagonal France [ ]  yes [ ]  no

[ ]  Lower respiratory tract sample with an isolated strain and at least one day at home in hexagonal France

[ ]  Lower respiratory tract sample with a PCR positive for Legionella and at least one day at home in hexagonal France

Patient’s consent for inclusion in the study : [ ]  yes [ ]  no

[ ]  Mailing or emailing of the information letter on : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

**Case identification**

**LEGIODOM : Case number** |\_\_\_\_\_\_| |\_\_\_\_\_\_\_| : *(Home region 3 letters, inclusion number)*

Date of birth : |\_\_\_\_\_\_\_| Gender : [ ]  M [ ]  F Postal code : |\_\_|\_\_|\_\_|\_\_|\_\_|

**Suspected clustered cases :** [ ]  yes [ ]  no

**2. DESCRIPTION**

**Clinical diagnostic :**

Date of symptom onset : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| Hospitalisation onset: |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Radiologically confirmed pneumonia [ ]  yes [ ]  no

If no, clinical signs  [ ]  yes  [ ]  no

Specify clinical signs if needed or comments : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Biological diagnostic :**

**Urinary antigen** : Date : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

[ ]  Positive [ ]  Négative [ ]  Not performed [ ]  Ininterpretable

**Lower respiratory tract sample** (including sputum and deep expectoration):

Done [ ]  Yes [ ]  No

Sampling date : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

If no, asked [ ]  Yes [ ]  No

Directly send to the CNR [ ]  Yes [ ]  No Date : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| *(if available)*

**Results**

PCR [ ]  Positive [ ]  Negative [ ]  Non performed

 Date of results : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| *(if available)*

Culture  [ ]  Positive [ ]  Negative [ ]  Non performed

 Date of results : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| *(if available)*

Send to the CNR [ ]  Yes [ ]  No Date of reception  |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| *(if available)*

Species/serogroup : [ ]  Lp1 [ ]  Other, specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genotyping ST : \_\_\_\_\_\_\_\_

**Comments : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Facteurs Favorisants :**

[ ]  Hemopathy or cancer [ ]  Cardiovascular disease

[ ]  Corticosteroid therapy [ ]  Diabetes

[ ] Other immunosuppressants [ ]  Renal insufficiency

[ ]  Solid organ transplant [ ]  Dialysis

[ ]  Smoking [ ]  Chronic lung disease (chronic bronchitis,

[ ]  Other, specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ emphysema, COPD)

[ ]  No predisposing factor

**Hospitalisation :**

Hospitalized [ ]  Yes [ ]  No

If yes : Date of hospitalization : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| Date of discharge : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Stay in intensive care [ ]  Yes [ ]  No

If yes : Date of entry : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| Date of discharge : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

**Evolution :**

At 4 weeks after symptom onset, the : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

[ ]  Discharged from the hospital

[ ]  Deceased, date of death : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

[ ]  Unknown

[ ]  Still hospitalized

 Service : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical condition : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Final evolution : the |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

[ ]  Recovered/Discharged

[ ]  Deceased, date of death : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

[ ]  Unknown

[ ]  Still hospitalized

Specify the service if needed : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LEGIODOM : N° Cas** |\_\_\_\_\_\_| |\_\_\_\_\_| **DO : Code d’anonymat** |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

**Identifiant ARS (**numéro SIVSS)**: |\_\_\_\_\_\_\_\_\_\_\_\_|**

**3. EXPOSITIONS**

**Date of symptom onset :** |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

**Exposition period** *(14 days before symptom onset)* **from** |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_| **to** |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

**Exposure Factors (Identify the places and activities at risk and the sectors where the person has traveled):**

*Conduct a history of places visited during the* ***14 days prior to the onset of symptoms****.* ***Possible sources of contamination*** *include: hot water systems (showers, taps), cooling systems and air-cooled towers, thermal waters, establishments with hot tubs (spas), decorative fountains, misters, devices for aerosol respiratory treatments (oxygen therapy, sleep apnea devices), dental unit, potting soil, etc.*

**MAIN RESIDENCE**

3.1 The case lives in :[ ]  A single-family house [ ]  An appartment in a residential building

[ ]  Another location, specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.2 The case is  : [ ]  Owner [ ]  Tenant [ ]  Don’t know

Owner’s/ landlord’s contact details : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.3 Is the source of domestic water :

[ ]  Public [ ]  Private (such as well, spring..) [ ]  Don’t know

3.4 If the case lives in a residential building: Is the hot water production for the residence?

[ ]  Individual [ ]  Collective [ ]  Don’t know

3.5 Is the hot water production ?

With storage tank (e.g., water heater): [ ]  Yes [ ]  No [ ]  Don’t know

Instantaneous production (e.g., water heater or boiler): [ ]  Yes [ ]  No [ ]  Don’t know

3.6 What energy source is used for hot water production? (Multiple answers possible):

[ ]  Gas-Electricity-Fuel [ ]  Solar [ ]  Heat Pump [ ]  Don’t know

3.7 How old is this hot water production system?

[ ]  ≤10 years [ ]  between 10 and <20 years [ ]  ≥ 20 years [ ]  Don’t know

3.8 Is the hot water production system maintained by a professional?

[ ]  Yes [ ]  No [ ]  Don’t know

If yes, specify the frequency : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.9 Have you observed that the domestic hot water is not hot enough? *(not used for LEGIODOM)*

[ ]  Yes [ ]  No [ ]  Don’t know

3.10 Have you observed that it takes more than 2 minutes to get hot water?

[ ]  Yes [ ]  No [ ]  Don’t know If yes, specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.11 Number of bathrooms with shower and/or bathtub in the residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.12 Is the main shower or bathtub equipped with :

[ ]  Separate taps (2 taps) [ ]  standard mixer tap (1 tap)

[ ]  Thermostatic mixer tap (temperature control ring) [ ]  Don’t know

**Regarding the exposure period :**

3.13 Have you experienced a disruption in your hot water supply in the 2 weeks preceding the onset of symptoms?

[ ]  Yes [ ]  No [ ]  Don’t know

If yes, specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.14 In the month preceding the onset of symptoms, were any plumbing works carried out on the hot water production system you use?

[ ]  Yes [ ]  No [ ]  Don’t know

If yes, specify the date and the type of work : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.15 Was the residence occupied during the entire month preceding the onset of symptoms?

[ ]  Yes [ ]  No [ ]  Don’t know

If not, approximatively how long was the duration of the absence

[ ]  <1 week [ ]  1 week and <2 weeks [ ]  2 weeks to <4 weeks

[ ]  form 4 weeks to 3 months [ ]  >3 months

Date of return to the case’s residence : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

3.16 Within the residence, is the shower used by the case on a daily basis?

[ ]  Yes [ ]  No [ ]  Don’t know

3.17 Did you, the case, have taken at home :

3.17.1 Baths : [ ]  Yes [ ]  No

If yes, how often : [ ]  Daily [ ]  Weekly [ ]  Other, specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.17.2 Showers: [ ]  Yes [ ]  No

If yes, how often : [ ]  Daily [ ]  Weekly [ ]  Other, specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.17.3 Washed at the sink only [ ]  Yes [ ]  No [ ]  Don’t know

3.17.4 Used a hot tube (jacuzzi, jetted bathtub)

[ ]  Yes [ ]  No [ ]  Don’t know

**LEGIODOM : N° Cas** |\_\_\_\_\_\_| |\_\_\_\_\_| **DO : Code d’anonymat** |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|

**Identifiant ARS (**numéro SIVSS)**: |\_\_\_\_\_\_\_\_\_\_\_\_|**

**RISK ACTIVITIES** : (Specify for each exposure)

[ ]  Professional (activity related to water from the sanitary network (shower) or process) : \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational physician’s contact details : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Leisure

Frequenting sports clubs with showers:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Swimming pool, spa, jacuzzi, steam room, balneotherapy, hot tub : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amusement park with water games: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Presence of misters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Do it yourself

Handling of equipment (at risk), hydraulic saw, pressure washer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plumbing work : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Gardening

Watering, spraying (conditions and location of water storage): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Handling potting soil (if commercial potting soil, specify brand, presence of a composter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Health

Dentist/physiotherapist (balneotherapy/shower): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical device (oxygen therapy, sleep apnea, aerosol...): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Practices

Carwash : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hairdresser : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequenting supermarket, shops, café terrace, restaurant (presence of misters): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRAVELS** (Establishment(s) visited specifying exact coordinates and period and report them in the table below) :

Home [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Healthcare facility [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thermal establishment [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EHPA – Nursing home [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hotel(s) [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(holiday villages etc…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Camping site(s)  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cottages, guesthouses [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Temporary residence  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(second home, family, friends ...) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cruise ship  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other  [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Calendar for places visited by the patient**

|  |  |  |
| --- | --- | --- |
|  | Date | Places visited |
| D -14 |  |  |
| D -13 |  |  |
| D -12 |  |  |
| D -11 |  |  |
| D -10 |  |  |
| D - 9 |  |  |
| D - 8 |  |  |
| D - 7 |  |  |
| D - 6 |  |  |
| D - 5 |  |  |
| D - 4 |  |  |
| D - 3 |  |  |
| D - 2 |  |  |
| D - 1 |  |  |
| D - 0 |  |  |

**Comments :**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Structures contactées pour suivi des actions à mener**

[ ]  EOHH: Hôpital de |\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_| date de contact |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Signalement d’infection nosocomiale effectué oui [ ]  non [ ]

Coordonnées de la personne contactée : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  SCHS: Ville de |\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_| date de contact |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Coordonnées de la personne contactée : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Médecin du travail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date de contact |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Coordonnées de la personne contactée : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Si séjour dans autre(s) région(s) :

Contact avec ARS |\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|: le |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Coordonnées de la personne contactée \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact avec ARS |\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|: le |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Coordonnées de la personne contactée \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Résultats des investigations environnementales** (à titre de suivi)

Domicile dans le cadre de l’étude LEGIODOM

Date de résultats des prélèvements environnementaux : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

 Recherche *Legionella spp* [ ]  Positive [ ]  Négative Taux : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recherche de *Legionella pneumophila* [ ]  Positive [ ]  Négative Taux: \_\_\_\_\_\_\_\_\_\_\_\_\_

Résultats des comparaisons des prélèvements ou souches cliniques et environnementales :

souches concordantes : [ ]  Oui [ ]  Non

Investigations réalisées en parallèle de l’étude LEGIO-DOM :

Détail des investigations environnementales : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Site de prélèvements : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date de résultats des prélèvements : |\_\_\_\_|\_\_\_\_|\_\_\_\_\_\_\_|

Recherche Legionella spp [ ]  Positive [ ]  Négative Taux : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recherche de *Legionella pneumophila* [ ]  Positive [ ]  Négative Taux: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Résultats des comparaisons des prélèvements ou souches cliniques et environnementales :

Souches concordantes : [ ]  Oui [ ]  Non

**LEGIODOM : N° Cas** |\_\_\_\_\_\_| |\_\_\_\_\_\_\_|

**SYNNTHESE DES EXPOSITIONS pour l’étude LEGIODOM**

**4 ACTIVITES A RISQUE** :

Séjour dans les 14 jours précédant la date de début des signes : [ ]  Oui [ ]  Non

Si OUI : Nombre de jours à domicile : |\_\_\_|\_\_\_|

Précisez les activités à risque :

[ ]  Voyage (séjour établissement de tourisme, famille, amis, résidence secondaire…)

[ ]  Etablissement de santé

[ ]  Professionnel (activité liée à l’eau du réseau sanitaire (douche) ou au process)

[ ]  Loisirs (douche, piscine, spa, jacuzzi, hammam, balnéothérapie)

[ ]  Bricolage (Manipulation d'outillage (à risque): scie hydraulique, karcher, travaux de plomberie

[ ]  Jardinage (Arrosage, pulvérisation, manipulation de terreau)

[ ]  Santé (Dentiste/balnéothérapie, oxygénothérapie, apnée du sommeil)

[ ]  Pas d’activité à risque

[ ]  Autres, préciser : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hors du domicile une comparaison de souches environnementales a-t-elle été réalisée au CNR**

[ ]  Oui [ ]  Non

Si oui précisez le lieu :

[ ]  Etablissement de santé [ ]  Etablissement thermal [ ]  EHPA-EHPAD

[ ]  Etablissement de tourisme (hôtel, camping, gîte, maison d’hôte, bateau de croisière)

[ ]  Résidence temporaire (résidence secondaire, amis, famille…)

[ ]  Etablissement recevant du public (loisir, piscine, spa, jacuzzi, stade…)

[ ]  Extérieur, jardin, terre, terreaux [ ]  Lieu de travail

[ ]  Autres, préciser : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Résultats des comparaisons : souches concordantes : [ ]  Oui [ ]  Non

Commentaires : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_