

COVID-19 CORE CASE REPORT FORM

ACUTE RESPIRATORY INFECTION CLINICAL CHARACTERISATION DATA TOOL

DESIGN OF THIS CASE REPORT FORM (CRF)

This CRF is set up in modules to be used for recording data on the ISARIC COVID-19 Core Database or for independent studies.

Module 1 and Module 2 complete on the first day of presentation/admission or on first day of COVID-19 assessment.

Module 2 also complete on first day of admission to ICU or high dependency unit, or if receiving critical care in any ward, and on any days that research specific samples are taken. In addition, complete daily if of interest for local, specific analysis. Continue to follow-up patients who transfer between wards.

Module 3 (Outcome) complete at discharge or death

GENERAL GUIDANCE

- The CRF is designed to collect data obtained through examination, interview and review of hospital notes. Data may be collected prospectively or retrospectively if the patient is enrolled after the admission date.
- For more detailed guidance on how to complete these forms, please refer to the CRF Completion Guideline
- Participant Identification Numbers consist of a 3 or 5 digit site code and a 4 digit participant number. You can obtain a site code and register on the data management system by contacting ncov@isaric.org. Participant numbers should be assigned sequentially for each site beginning with 0001. In the case of a single site recruiting participants on different wards, or where it is otherwise difficult to assign sequential numbers, it is acceptable to assign numbers in blocks or incorporate alpha characters. E.g. Ward X will assign numbers from 0001 or A001 onwards and Ward Y will assign numbers from 5001 or B001 onwards. Enter the Participant Identification Number at the top of every page.
- Printed paper CRFs may be used for later transfer of the data onto the electronic database.
- For participants who return for re-admission to the same site, **start a new form with a different Participant Identification Number**. Please check “YES-admitted previously to this facility” in the RE-ADMISSION section. Enter as 2 separate entries in the electronic database.
- For participants who transfer between two sites that are both collecting data on this form, it is preferred to have the data entered by a single site as a single admission, under the same Participant Identification Number. When this is not possible, the first site should record “Transfer to other facility” as an OUTCOME, and the second site should start a new form with a new patient number and indicate “YES-transferred from other facility” RE-ADMISSION.
- Complete every line of every section, except where the instructions say to skip a section based on a response.
- Selections with circles (●) are single selection answers (choose one answer only). Selections with square boxes (□) are multiple selection answers (choose as many answers as are applicable).
- Mark ‘Not done’ for any results of laboratory values that are not available, not applicable or unknown.
- Avoid recording data outside of the dedicated areas. Sections are available for recording additional information.
- If using paper CRFs, we recommend writing clearly in ink, using BLOCK-CAPITAL LETTERS.
- Place an (X) when you choose the corresponding answer. To make corrections, strike through (-----) the data you wish to delete and write the correct data above it. Please initial and date all corrections.
- Please keep all of the sheets for a single participant together e.g. with a staple or participant-unique folder.
- Please transfer all paper CRF data to the electronic database. All paper CRFs needs to be stored locally, do not send any forms to us. Data are accepted only via secure electronic database.
- Please enter data on the electronic data capture system at <https://ncov.medsci.ox.ac.uk/>. If your site would like to collect data independently, we are happy to support the establishment of locally hosted databases.
- Please contact us at ncov@isaric.org if you need help with databases, if you have comments and to let us know that you are using the forms.

MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

CLINICAL INCLUSION CRITERIA

Suspected or confirmed novel coronavirus (COVID-19) infection: YES NO

Is COVID-19 the reason for hospital admission?

Yes, COVID-19 is the reason for hospital admission

No, the patient is admitted to hospital for a reason other than COVID-19

DEMOGRAPHICS

Clinical centre name: _____ Country: _____

Enrolment date /first COVID-19 assessment date: [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_] [_] [_]

Ethnic group (check all that apply): Arab Black East Asian South Asian West Asian Latin American White
 Aboriginal/First Nations Other: _____ Unknown

Employed as a Healthcare Worker? YES NO Unknown Employed in a microbiology laboratory? YES NO Unknown

Sex at Birth: Male Female Not specified/Unknown Age [_] [_] [_] years OR [_] [_] months

Pregnant? YES NO Unknown If YES: Gestational weeks assessment: [_] [_] weeks

POST PARTUM (within 6 weeks of delivery)? YES NO Unknown (if NO or Unknown skip this section)

Pregnancy Outcome: Live birth Still birth Delivery date: [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_] [_] [_]

Baby tested for COVID-19/SARS-CoV-2 infection? YES NO Unknown

If YES, result of test: Positive Negative Unknown (If Positive, complete a separate CRF for baby)

INFANT – Less than 1 year old? YES NO (If NO skip this section)

Birth weight: [_] [_] . [_] kg or lbs Unknown

Gestational outcome: Term birth (≥37wk GA) Preterm birth (<37wk GA) Unknown

Breastfed? YES-currently breastfeeding YES-breastfeeding discontinued NO Unknown

Vaccinations appropriate for age/country? YES NO Unknown

PREVIOUS COVID-19 INFECTIONS

Has the patient had COVID-19 previously?

No Yes - once previously Yes - twice previously Yes - three times previously

(there is more space on the eCRF to capture this)

First COVID-19 infection: When did their first COVID infection occur? (MM/YYYY) _____

Was their first COVID infection confirmed by testing: Yes, confirmed by testing No, not confirmed by testing

Were they admitted to hospital for their first infection of COVID? Yes No

Second COVID-19 infection: When did their second COVID infection occur? (MM/YYYY) _____

Was their second COVID infection confirmed by testing: Yes, confirmed by testing No, not confirmed by testing

Were they admitted to hospital for their second infection of COVID? Yes No

If data on this patient was previously recorded in this study, record the Participant Identification Number (PIN) previously used in the section below

MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

RE-ADMISSION AND PREVIOUS PIN

Was the patient admitted previously or transferred from any other facility during this illness episode?

YES-admitted previously to this facility YES-transferred from other facility NO Unknown

Number of previous admissions for this infection: _____

Has this patient's data been previously collected under a different patient number? YES NO Unknown

If YES, Participant Identification number (PIN): _____

ONSET & ADMISSION

Onset date of first/earliest symptom: [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_]

Most recent presentation/admission date at this facility: [_] [_] [_] / [_] [_] [_] / [_] [_] [_] [_]

SIGNS AND SYMPTOMS AT HOSPITAL ADMISSION (first available data at presentation/admission – within 24 hours)

Temperature: [_] [_] [_] . [_] °C or °F

HR: [_] [_] [_] beats/minute

RR: [_] [_] breaths/minute

Systolic BP: [_] [_] [_] mmHg Diastolic BP: [_] [_] [_] mmHg

Oxygen saturation: [_] [_] [_] % On: Room air Oxygen therapy Unknown

Sternal capillary refill time >2sec. YES NO Unknown

Height: [_] [_] [_] cm

Weight: [_] [_] [_] kg

SIGNS AND SYMPTOMS ON ADMISSION (Unk = Unknown)

History of fever	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Fatigue / Malaise	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Cough <input type="radio"/> YES - non-productive <input type="radio"/> YES - productive <input type="radio"/> YES - with haemoptysis <input type="radio"/> NO <input type="radio"/> Unk		Anorexia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
		Altered consciousness/confusion	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Sore throat	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Muscle aches (myalgia)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Runny nose (rhinorrhoea)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Joint pain (arthralgia)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Wheezing	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Inability to walk	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Shortness of breath	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Abdominal pain	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Lower chest wall indrawing	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Diarrhoea	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Chest pain	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Vomiting / Nausea	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Conjunctivitis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Skin rash	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Lymphadenopathy	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Bleeding (Haemorrhage)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Headache	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	If YES, specify site(s): _____	
Loss of smell (Anosmia)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Other symptom(s)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Loss of taste (Ageusia)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	If YES, specify: _____	
Seizures	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk		

MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

VACCINATIONS	
Covid-19 vaccination: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	
Date of first vaccine : [] [] [] / [] [] [] / [] [] [] [] [] [] Date: <input type="radio"/> Actual <input type="radio"/> Estimated	
Type of first vaccine: <input type="radio"/> Pfizer/BioNTech <input type="radio"/> AstraZeneca Oxford (Covishield in India) <input type="radio"/> Moderna <input type="radio"/> Novavax <input type="radio"/> Janssens (Johnson & Johnson) <input type="radio"/> Sinopharm <input type="radio"/> Sinovac <input type="radio"/> Sputnik V <input type="radio"/> Covaxin <input type="radio"/> CanSinoBIO <input type="radio"/> Unknown <input type="radio"/> Other, please specify _____	
Date of second vaccine : [] [] [] / [] [] [] / [] [] [] [] [] [] Date: <input type="radio"/> Actual <input type="radio"/> Estimated	
Type of second vaccine: <input type="radio"/> Pfizer/BioNTech <input type="radio"/> AstraZeneca/University of Oxford (Covishield in India) <input type="radio"/> Moderna <input type="radio"/> Novavax <input type="radio"/> Janssens (Johnson & Johnson) <input type="radio"/> Sinopharm <input type="radio"/> Sinovac <input type="radio"/> Sputnik V <input type="radio"/> Covaxin <input type="radio"/> CanSinoBIO <input type="radio"/> Unknown <input type="radio"/> Other, please specify _____	
Date of third vaccine : [] [] [] / [] [] [] / [] [] [] [] [] [] Date: <input type="radio"/> Actual <input type="radio"/> Estimated	
Type of third vaccine: <input type="radio"/> Pfizer/BioNTech <input type="radio"/> AstraZeneca/University of Oxford (Covishield in India) <input type="radio"/> Moderna <input type="radio"/> Novavax <input type="radio"/> Janssens (Johnson & Johnson) <input type="radio"/> Sinopharm <input type="radio"/> Sinovac <input type="radio"/> Sputnik V <input type="radio"/> Covaxin <input type="radio"/> CanSinoBIO <input type="radio"/> Unknown <input type="radio"/> Other, please specify _____	
Influenza vaccination within the last 6 months: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	
Date of influenza vaccine : [] [] [] / [] [] [] / [] [] [] [] [] [] Date: <input type="radio"/> Actual <input type="radio"/> Estimated	

PRE-ADMISSION MEDICATION <i>(taken within 14 days prior to admission/presentation at healthcare facility)</i>	
Steroids	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES, <input type="radio"/> Oral <input type="radio"/> Inhaled <input type="radio"/> Unk
Other immunosuppressant agents (not oral steroids)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Antibiotics	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES, agent(s): _____
Antivirals	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES, agent(s): _____
Other targeted COVID-19 Medications	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES, agent(s): _____

CO-MORBIDITIES AND RISK FACTORS <i>(existing prior to admission and ongoing)</i>			
Chronic cardiac disease <i>(not hypertension)</i>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Chronic hematologic disease	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Hypertension	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	AIDS / HIV <input type="radio"/> YES-on ART <input type="radio"/> YES-not on ART <input type="radio"/> NO <input type="radio"/> Unk If YES, most recent CD4 count: <input type="radio"/> < 200 <input type="radio"/> 200-< 500 <input type="radio"/> ≥ 500 cells/uL <input type="radio"/> Unk	
Chronic pulmonary disease <i>(not asthma)</i>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Diabetes Mellitus <input type="radio"/> YES-Type 1 <input type="radio"/> YES -Type 2 <input type="radio"/> YES -Gestational <input type="radio"/> NO <input type="radio"/> Unk If YES, HbA1C results (within last 6 months) : _____ Units: <input type="radio"/> mmol/mol <input type="radio"/> mmol/L <input type="radio"/> %	
Asthma <i>(physician diagnosed)</i>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Rheumatologic disorder	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Chronic kidney disease	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Dementia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Obesity <i>(as defined by clinical staff)</i>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Tuberculosis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Moderate or severe liver disease	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Malnutrition	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Mild liver disease	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Smoking <input type="radio"/> YES <input type="radio"/> Never smoked <input type="radio"/> Former smoker <input type="radio"/> Unk	
Asplenia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Other relevant risk factor(s) <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	
Chronic neurological disorder	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	If YES, specify:	
Malignant neoplasm	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk		

MODULE 2: CASE REPORT FORM ON ADMISSION, CRITICAL CARE, RESEARCH SAMPLING

Complete on the day of admission or first COVID-19 investigation, and on the first day of ICU admission (if different from day of admission). In addition, complete for days when biochemical results are available.

SIGNS AND SYMPTOMS (Record the worst value between 00:00 to 24:00 on day of assessment)(worst=furthest from normal range)
DATE OF ASSESSMENT (DD/MM/YYYY): [D][D]/[M][M]/[2][0][Y][Y]
Highest temperature: [][][]·[][] °C or °F HR: [][][]beats/minute RR: [][][]breaths/minute
Systolic BP: [][][]mmHg Diastolic BP: [][][]mmHg
Oxygen saturation SaO ₂ [][][]%
Any supplemental oxygen: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If yes,
FiO ₂ (0.21-1.0) [][]·[][][] or [][][] % or [][][]L/min (Highest L/min)
PaO ₂ (at time nearest to the FiO ₂ recorded at top of page) [][][][] <input type="radio"/> kPa or <input type="radio"/> mmHg <input type="radio"/> Not done
PaO ₂ sample type: <input type="radio"/> Arterial <input type="radio"/> Capillary <input type="radio"/> Venous <input type="radio"/> Unknown
From same blood gas record as PaO ₂ :
PCO ₂ _____ <input type="radio"/> kPa or <input type="radio"/> mmHg pH _____ HCO ₃ ⁻ _____ mEq/L Base excess _____ mmol/L
Sternal capillary refill time >2seconds <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
AVPU: Alert [][] Verbal [][] Pain [][] Unresponsive [][] Glasgow Coma Score (GCS / 15) [][][]
Richmond Agitation-Sedation Scale (RASS) [][]
Mean Arterial Blood Pressure [][][][]mmHg <input type="radio"/> Unknown
Urine flow rate [][][][][]mL/24 hours <input type="radio"/> Check if estimated <input type="radio"/> Unknown

Is the patient currently receiving, or has received (between 00:00 to 24:00 on day of assessment)
Current admission to ICU/ITU/IMC/HDU? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
High-flow nasal cannula oxygen therapy? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
Non-invasive ventilation (Any)? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES: <input type="radio"/> BIPAP <input type="radio"/> CPAP <input type="radio"/> Other <input type="radio"/> Unknown
Invasive ventilation? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
Prone positioning? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If yes, <input type="radio"/> during invasive ventilation <input type="radio"/> whilst self-ventilating <input type="radio"/> Unknown
Inhaled Nitric Oxide? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
Tracheostomy inserted? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
Extra corporeal life support (ECLS/ ECMO)? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES: <input type="radio"/> VV <input type="radio"/> AV <input type="radio"/> Central <input type="radio"/> Unknown
Renal replacement therapy (RRT) or dialysis? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
Any vasopressor/inotropic support? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown (if NO, select NO for the next 3 questions)
Dopamine <5µg/kg/min OR Dobutamine OR milrinone OR levosimendan: <input type="radio"/> YES <input type="radio"/> NO
Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine: <input type="radio"/> YES <input type="radio"/> NO
Dopamine >15µg/k/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: <input type="radio"/> YES <input type="radio"/> NO
Neuromuscular blocking agents? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown
Other intervention(s) or procedure(s)? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES, Specify: _____

MODULE 2: CASE REPORT FORM ON ADMISSION, CRITICAL CARE, RESEARCH SAMPLING

Complete on the day of admission or first COVID-19 investigation, and on the first day of ICU admission (if different from day of admission). In addition, complete for days when biochemical results are available.

LABORATORY RESULTS (on admission, on any admission to ICU, then daily) – complete every line					
DATE OF ASSESSMENT (DD/MM/YYYY): [_] [_] / [_] [_] / [2] [0] [_] [_]					
LABORATORY RESULTS (*record units if different from those listed)					
Record the worst value between 00:00 to 24:00 on day of assessment (if Not Available write 'N/A')					
Parameter	Value*	Not done	Parameter	Value*	Not done
Haemoglobin (g/L)		<input type="radio"/>	Urea (BUN) (mmol/L)		<input type="radio"/>
WBC count (x10 ⁹ /L)		<input type="radio"/>	Lactate (mmol/L)		<input type="radio"/>
Lymphocyte count (10 ⁹ /L)		<input type="radio"/>	Creatinine (µmol/L)		<input type="radio"/>
Neutrophil count (10 ⁹ /L)		<input type="radio"/>	Sodium (mmol/L)		<input type="radio"/>
Haematocrit (%)		<input type="radio"/>	Potassium (mmol/L)		<input type="radio"/>
Platelets (x10 ⁹ /L)		<input type="radio"/>	Procalcitonin (ng/mL)		<input type="radio"/>
APTT (seconds)		<input type="radio"/>	CRP (mg/L)		<input type="radio"/>
APTR		<input type="radio"/>	LDH (U/L)		<input type="radio"/>
PT (seconds)		<input type="radio"/>	Creatine kinase (U/L)		<input type="radio"/>
INR		<input type="radio"/>	Troponin I (ng/mL)		<input type="radio"/>
ALT/SGPT (U/L)		<input type="radio"/>	D-dimer (mg/L)		<input type="radio"/>
Total bilirubin (µmol/L)		<input type="radio"/>	Ferritin (ng/mL)		<input type="radio"/>
AST/SGOT (U/L)		<input type="radio"/>	IL-6 (pg/mL)		<input type="radio"/>
Glucose (mmol/L)		<input type="radio"/>	Fibrinogen (mg/dl)		<input type="radio"/>

MODULE 3: OUTCOME CASE REPORT FORM

TREATMENT: At ANY time during hospitalisation, did the patient receive/undergo:	
Any Oxygen therapy? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	If YES, total duration: _____ days <input type="radio"/> Unknown
Maximum O ₂ flow volume: <input type="radio"/> <2 L/min <input type="radio"/> 2-5 L/min <input type="radio"/> 6-10 L/min <input type="radio"/> 11-15 L/min <input type="radio"/> >15 L/min	
Non-invasive ventilation? (Any) <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	If YES, total duration: _____ days <input type="radio"/> Unknown
Invasive ventilation? (Any) <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	If YES, total duration: _____ days <input type="radio"/> Unknown
High flow nasal oxygen <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	If YES, total duration: _____ days <input type="radio"/> Unknown
Prone Positioning? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	
Inhaled Nitric Oxide? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	
Tracheostomy inserted? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	
Extracorporeal support (ECMO)? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	If YES, total duration: _____ days <input type="radio"/> Unknown
Renal replacement therapy (RRT) or dialysis? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	
Inotropes/vasopressors? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	
ICU or High Dependency Unit admission? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown	If YES, total duration: _____ days <input type="radio"/> Unknown
If YES, date of ICU admission: [_] [_] / [_] [_] / [2] [0] [_] [_]	<input type="radio"/> Unknown
date of ICU discharge: [_] [_] / [_] [_] / [2] [0] [_] [_]	<input type="radio"/> Unknown

MODULE 3: OUTCOME CASE REPORT FORM

COMPLICATIONS: At any time during hospitalisation did the patient experience: (Unk = Unknown)			
Viral pneumonia/pneumonitis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Meningitis / Encephalitis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Bacterial pneumonia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Bacteremia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Acute Respiratory Distress Syndrome	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Coagulation disorder / DIC	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Pneumothorax	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Pulmonary Embolism	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Pleural effusion	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Deep Vein Thrombosis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Cryptogenic organizing pneumonia (COP)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Other thromboembolism (not PE or DVT)	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Bronchiolitis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Anemia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Cardiac arrest	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Rhabdomyolysis / Myositis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Myocardial infarction	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Acute renal injury/ Acute renal failure	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Cardiac ischaemia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Gastrointestinal haemorrhage	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Cardiac arrhythmia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Pancreatitis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Myocarditis / Pericarditis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Liver dysfunction	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Endocarditis	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Hyperglycemia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Cardiomyopathy	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Hypoglycemia	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk
Congestive heart failure	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	Other <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES, specify: _____	
Seizure	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk		
Stroke / Cerebrovascular accident	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk		

DIAGNOSTICS
<p>Section 1: RESPIRATORY VIRUS PCR TESTING</p> <p>SARS-CoV-2 (COVID-19): <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p> <p>Was other pathogen testing done during this illness episode? <input type="radio"/> YES (complete section) <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>Influenza : <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p> <p>If Positive: <input type="radio"/> A-not typed <input type="radio"/> A/H3N2 <input type="radio"/> A/H1N1pdm09 <input type="radio"/> A/H7N9 <input type="radio"/> A/H5N1 <input type="radio"/> B <input type="radio"/> Other: _____ ..<input type="radio"/> Unk</p> <p>Respiratory Syncytial Virus (RSV): <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p> <p>Adenovirus: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done <input type="radio"/> Unknown</p>
<p>Section 2: BACTERIAL TESTING</p> <p>Bacteria: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not done If Positive, specify: _____ <input type="radio"/> Unknown</p> <p>Other pathogen/s detected: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES, specify all: _____ <input type="radio"/> Unknown</p>
<p>Section 3: RADIOLOGY</p> <p>Clinical pneumonia diagnosed? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>Chest X-Ray performed? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If Yes: Were infiltrates present? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>CT performed? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If Yes: Were infiltrates present? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p>

MODULE 3: OUTCOME CASE REPORT FORM

<i>MEDICATION (continued):</i>	
ANTIBIOTIC? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If yes, specify all:	
Agent 1: _____	Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] Duration: _____ days <input type="radio"/> Unk
Agent 2: _____	Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] Duration: _____ days <input type="radio"/> Unk
Agent 3: _____	Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] Duration: _____ days <input type="radio"/> Unk
CORTICOSTEROID? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES: Dexamethasone? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES, check all that apply: <input type="checkbox"/> 6mg once per day (od)? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES, Route: <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="radio"/> Unk If YES, Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] Duration: _____ days <input type="radio"/> Unk <input type="checkbox"/> other dose or frequency? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES, Route: <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="radio"/> Unk If YES, Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] Duration: _____ days <input type="radio"/> Unk If YES: Other corticosteroid? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown If YES: Which steroid: <input type="checkbox"/> Prednisolone <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Methylprednisolone <input type="checkbox"/> Other Route: <input type="checkbox"/> Oral <input type="checkbox"/> Intravenous <input type="radio"/> Unk	
ANTICOAGULATION? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES: Agent: _____ Route: <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Intravenous (IV) <input type="radio"/> Unk Indication: <input type="checkbox"/> therapeutic (treatment of DVT/PE) <input type="checkbox"/> enhanced prophylaxis for COVID-19 <input type="checkbox"/> routine inpatient prophylaxis <input type="checkbox"/> Unk	
ANTIFUNGAL AGENT? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk	
OTHER treatments administered for COVID-19 including experimental or compassionate use? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unk If YES, specify agent and timing of administration: Agent 1: _____ Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] <input type="radio"/> Unk Duration: _____ days <input type="radio"/> Unk Agent 2: _____ Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] <input type="radio"/> Unk Duration: _____ days <input type="radio"/> Unk Agent 3: _____ Date commenced [_] [_] / [_] [_] / [2] [0] [_] [_] <input type="radio"/> Unk Duration: _____ days <input type="radio"/> Unk	

MODULE 3: OUTCOME CASE REPORT FORM

OUTCOME
<p>Was patient diagnosed with Covid-19? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>If yes, was the diagnosis based on: <input type="radio"/> laboratory confirmation <input type="radio"/> clinical assessment</p> <p>Is the patient infected with a variant of concern (VOC)?</p> <p><input type="radio"/> Unknown</p> <p><input type="radio"/> No: Variant is known and no VOC identified</p> <p><input type="radio"/> Yes: Delta - B.1.617.2, identified Oct 2020</p> <p><input type="radio"/> Yes: Omicron, B.1.1.529, identified Nov 2021</p> <p><input type="radio"/> Yes: Alpha - B.1.1.7, identified in UK Sept 2020</p> <p><input type="radio"/> Yes: Beta - B.1.351, identified in South Africa May 2020</p> <p><input type="radio"/> Yes: Gamma - P.1, identified in Brazil Nov 2020</p> <p><input type="radio"/> Yes: Epsilon - B.1.427/B.1.429, identified in USA Mar 2021</p> <p><input type="radio"/> Yes: Zeta - P.2, identified in Brazil Apr 2020</p> <p><input type="radio"/> Yes: Eta - B.1.525, identified in Multiple Countries Dec 2020</p> <p><input type="radio"/> Yes: Theta - P.3, identified in Philippines Jan 2021</p> <p><input type="radio"/> Yes: Iota - B.1.526, identified in USA Nov 2020</p> <p><input type="radio"/> Yes: Kappa - B.1.617.1, identified in India Oct 2020</p> <p><input type="radio"/> Yes: Lambda - C.37, identified in Peru Dec 2020</p> <p><input type="radio"/> Yes: Mu - B.1.621, identified in Colombia Jan 2021</p> <p><input type="radio"/> Yes: A variant not listed above</p> <p><i>Please check the REDCAP database for variants not listed above. New variants will be added to the database as they are identified.</i></p> <p>If the Omicron variant was identified, what method was used to identify it?</p> <p><input type="radio"/> Genomic sequencing <input type="radio"/> S-gene target failure (SGTF) testing <input type="radio"/> PCR genotyping <input type="radio"/> Unknown or untested</p> <p>Outcome: <input type="radio"/> Discharged alive <input type="radio"/> Hospitalised <input type="radio"/> Transfer to other facility <input type="radio"/> Death <input type="radio"/> Palliative discharge <input type="radio"/> Unknown</p> <p>Outcome date: [_] [_] / [_] [_] / [_] [_] [_] [_] <input type="radio"/> Unknown</p> <p>If alive at outcome date:</p> <p>Ability to self-care at discharge versus before illness: <input type="radio"/> Same as before illness <input type="radio"/> Worse <input type="radio"/> Better <input type="radio"/> Unknown</p> <p>Post-discharge treatment: Oxygen therapy? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>Ongoing health care needs relating to this admission for COVID-19: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>Ongoing health care needs NOT related to COVID episode: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p> <p>Medically fit for discharge (COVID-19 resolved) but remains in hospital for other reason (e.g. awaiting suitable care in community, resident in long term health care or mental health facility): <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown</p>