ISARIC/WHO Clinical Characterisation Protocol CASE REPORT FORM

DESIGN OF THE CCP-Global CASE REPORT FORM (CRF) - Version 1JUN22

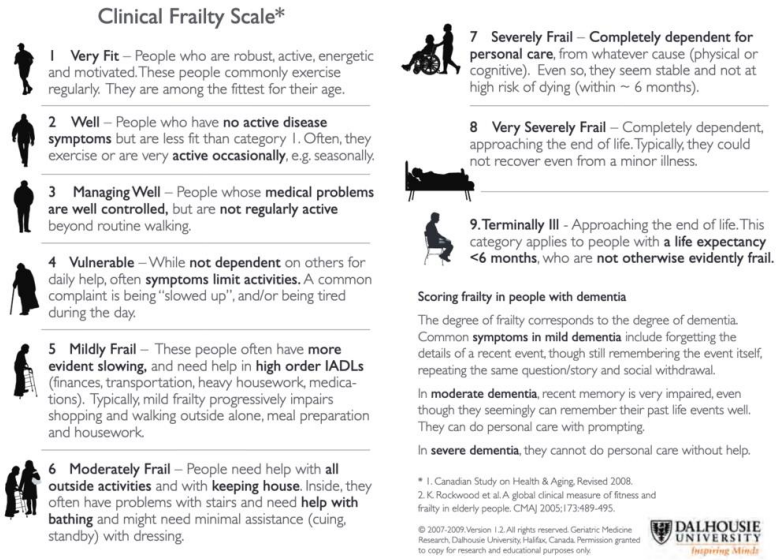
This CRF is divided into a "**ADMISSION**" form, a "**DAILY**" form for daily clinical and laboratory and data, an "**OUTCOME**" form, and additional modules for pregnancy and specific diseases.

GENERAL GUIDANCE

- The CRF is designed to collect data obtained through examination, interview and review of hospital notes. Data may be collected retrospectively if the patient is enrolled after the admission date or deceased after admission.
- Participant Identification Numbers consist of a 5-digit site number and a 4 or 5-digit participant number. Obtain a site code by contacting data@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. E.g. Ward X will assign numbers from 0001 onwards and Ward Y will assign numbers from 5001 onwards. Enter the Participant Identification Number at the top of every page.
- **Please generate a new subject ID for each re-admission**
- CRF data should be entered to the central database at https://ncov.medsci.ox.ac.uk./To register for access or for support, please contact data@isaric.org

FORM COMPLETION GUIDANCE

- Ideally complete every line of every section, except for where the instructions say to skip a section based on certain responses. This may not be possible in surge conditions.
- Selections with square boxes (☐) are single selection answers (choose one answer only). Selections with circles (**o**) are multiple selection answers (choose as many answers as are applicable).
- Some fields are considered **URGENT AND ESSENTIAL**. These are marked **BOLD AND UNDERLINED**
  IN ALL CIRCUMSTANCES PLEASE PRIORITISE THESE DATA POINTS FOR URGENT UPLOAD.
- Mark 'N/K' for any information, data or results of laboratory values that are not known or not available.
- In the case of a participant transferring between study sites, it is preferred to maintain the same Participant Identification Number across the sites. When this is not possible a new Participant Identification Number should be assigned and recorded on the OUTCOME form.
- The Dalhousie University Clinical Frailty Score is provided below for your reference.



ISARIC WHO Clinical Characterisation Protocol
ADMISSION FORM

Date of enrolment [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] **Site Location**_____

CLINICAL INCLUSION CRITERIA

Proven infection with pathogen of Public Health Interest: ☐ YES ☐ NO

OR

High suspicion of exposure to pathogen, noxious agent or harmful energy of Public Health Interest: ☐ YES ☐ NO

*N.B. This does **not** relate to covid-19 exposure. This does include children with hepatitis of unknown cause.*

Which of the following is the individual proven/suspected of having?

O Andes virus infection (hantavirus) O Argentine haemorrhagic fever (Junin virus) O Avian influenza A H7N9 & H5N1

O Avian influenza A H5N6 & H7N7 O Bolivian haemorrhagic fever (Machupo virus) O Crimean Congo haemorrhagic fever (CCHF)

O Ebola virus disease (EVD) O Exposure to CBRN agent O Lassa fever O Lujo virus disease O Marburg virus disease (MVD)

O Middle East respiratory syndrome (MERS) O Monkeypox O Nipah virus infection O Pneumonic plague (Yersinia pestis)

O Severe acute respiratory syndrome (SARS-not COVID-19) O Severe fever with thrombocytopaenia syndrome (SFTS)

O Exposure to CBRN agent O Exposure to Harmful Energy O Paediatric hepatitis (unknown cause)

O Other, specify: _____ O Unknown

DEMOGRAPHICS

Sex at Birth: ☐ Male ☐ Female ☐ Not specified **Date of birth** [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

If date of birth is Not Known (N/K) record Age: [___][___][___]years **OR** [___][___]months

Ethnic group *(check all that apply)*:

O Arab O Black O East Asian O South Asian O West Asian O Latin American O White O Aboriginal/First Nations

O Other: _____ ☐N/K

Employed as a Healthcare Worker? ☐YES ☐NO ☐N/K

Pregnant? ☐ YES ☐ NO ☐ N/K If YES: Gestational weeks assessment: [___][___] weeks

POST PARTUM (within six weeks of delivery)? ☐YES ☐NO or ☐N/K *(skip this section - go to INFANT)*

Pregnancy Outcome: ☐Live birth ☐Still birth Delivery date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Has infant(s) been tested for Mother's infection? ☐YES ☐NO ☐N/K If YES: ☐Positive ☐Negative

IF POSITIVE PLEASE COMPLETE A SEPARATE CASE REPORT FORM FOR THE INFANT(s)

INFANT – Less than 1 year old? ☐YES ☐NO *(skip this section)* Birth weight: [___].[___]kg ☐N/K

Gestational: ☐ Term birth (≥37wk GA) ☐Preterm birth (<37wk GA) if <37wk Estimated gestation _____weeks ☐N/K

Breastfed? ☐YES ☐NO ☐N/K If YES: ☐Currently breastfed ☐Breastfeeding discontinued ☐N/K

ONSET AND ADMISSION/PRESENTATION

Date of first/earliest symptom: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] **OR** ☐ **Asymptomatic**

Admission date at this facility: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

If not admitted: Date of first presentation at out-patient facility: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Transfer from other facility? ☐YES-other facility is a study site ☐YES-other facility is not a study site ☐NO ☐N/K

If YES: Name of prior facility:_____ ☐N/K

If YES: Admission date at previous facility *(DD/MM/YYYY)*: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/K

If YES-Study Site: Participant ID # at previous facility: I__I I__I I__I I__I I__I -- I__I I__I I__I I__I I__I

OR ☐Same as above

SIGNS AND SYMPTOMS at ADMISSION- *This section should refer to features at presentation i.e. the start of this* episode

None (asymptomatic) ☐

History of fever	☐YES ☐NO ☐N/K	Vomiting / Nausea	☐YES ☐NO ☐N/K
Runny nose (Rhinorrhoea)	☐YES ☐NO ☐N/K	Diarrhoea	☐YES ☐NO ☐N/K
Sore throat	☐YES ☐NO ☐N/K	Abdominal pain	☐YES ☐NO ☐N/K
Disturbance or loss of taste (Ageusia)	☐YES ☐NO ☐N/K	Jaundice	☐YES ☐NO ☐N/K
Disturbance or loss of smell (Anosmia)	☐YES ☐NO ☐N/K		
Ear pain	☐YES ☐NO ☐N/K	Fatigue / Malaise	☐YES ☐NO ☐N/K
Cough	☐YES ☐NO ☐N/K	Headache	☐YES ☐NO ☐N/K
with sputum production	☐YES ☐NO ☐N/K	Altered consciousness/confusion	☐YES ☐NO ☐N/K
bloody sputum/haemoptysis	☐YES ☐NO ☐N/K	Seizures	☐YES ☐NO ☐N/K
Wheezing	☐YES ☐NO ☐N/K		
Chest pain	☐YES ☐NO ☐N/K	Keratitis	☐YES ☐NO ☐N/K
Shortness of breath (Dyspnoea)	☐YES ☐NO ☐N/K	Conjunctivitis	☐YES ☐NO ☐N/K
Lower chest wall indrawing	☐YES ☐NO ☐N/K	Pruritis	☐YES ☐NO ☐N/K
		Skin rash including vesicles	☐YES ☐NO ☐N/K
Muscle aches (Myalgia)	☐YES ☐NO ☐N/K	Skin ulcers	☐YES ☐NO ☐N/K
Joint pain (Arthralgia)	☐YES ☐NO ☐N/K	Lymphadenopathy	☐YES ☐NO ☐N/K
Weight loss	☐YES ☐NO ☐N/K	Bleeding (Haemorrhage)	☐YES ☐NO ☐N/K
		If Bleeding: specify site(s) e.g. vesicles, vagina:	_____ _____

VITAL SIGNS AT HOSPITAL ADMISSION *-first available data at presentation/Admission to the facility.*

(This section should refer to data from the date of admission to this facility)

Temperature: [___][___].[___]°C **HR:** [_____][_____][_____]**beats per minute** **RR:** [_____][_____]**breaths per minute**

Systolic BP: [____] [____] [____]**mmHg** **Diastolic BP:** [____][____] [____]**mmHg** **Severe dehydration:** ☐YES ☐NO ☐N/K

Sternal capillary refill time >2seconds ☐YES ☐NO ☐N/K

Oxygen saturation: [____][____][____]% **On:** ☐Room air ☐Any Oxygen therapy ☐N/K

CO-MORBIDITIES *(existing prior to admission)*			**No comorbidities ☐**
Chronic cardiac disease, including congenital heart disease. *(not hypertension)*	**☐YES ☐NO ☐N/K**	**Obesity *(as defined by clinical staff)***	**☐YES ☐NO ☐N/K**
Hypertension *(physician diagnosed)*	**☐YES ☐NO ☐N/K**	**Diabetes and Type**	**☐YES-type 1 ☐NO ☐YES-type 2 ☐N/K**
Chronic pulmonary disease *(not asthma)*	**☐YES ☐NO ☐N/K**	**Diabetes (any) with complications**	**☐YES ☐NO ☐N/K**
Asthma *(physician diagnosed)*	**☐YES ☐NO ☐N/K**	**Diabetes (any) without complications**	**☐YES ☐NO ☐N/K**
Chronic kidney disease	**☐YES ☐NO ☐N/K**	**Rheumatologic disorder**	**☐YES ☐NO ☐N/K**
Moderate / severe liver disease	**☐YES ☐NO ☐N/K**	**Dementia**	**☐YES ☐NO ☐N/K**
Mild liver disease	**☐YES ☐NO ☐N/K**	**Malnutrition**	**☐YES ☐NO ☐N/K**
Chronic neurological disorder	**☐YES ☐NO ☐N/K**	**Smoking ☐YES ☐Never smoked ☐Former smoker ☐N/K**	
Malignant neoplasm	**☐YES ☐NO ☐N/K**	**Other relevant risk factor**	
Chronic hematologic disease	**☐YES ☐NO ☐N/K**	**☐YES ☐NO ☐N/K**	
AIDS / HIV	**☐YES-on ARV ☐NO ☐YES-not on ARV ☐N/K**	**If yes, specify_____**	

CLINICAL FRAILTY SCORE for people age over 18 years **With reference to the Dalhousie University Clinical Frailty Score (see guidance on CRF)**	
Clinical Frailty Score	[___] value 1 to 9 or ☐N/K

MEDICATION ON ADMISSION **Record medication the patient was taking just prior to admission and has taken within the past 14 days**
Medication name *(generic name preferred-please write in CAPITALS):*

ISARIC WHO Clinical Characterisation Protocol

DAILY FORM

DAILY TREATMENT *(complete every line)*:

DATE OF ASSESSMENT *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Record the worst value between 00:00 to 24:00 on day of assessment *(if Not Available write 'N/K')*:

Is the patient in a high-level care area i.e. admitted to ICU/ITU/IMC/HDU ☐YES ☐NO ☐N/K

Highest Temperature: [_][__].[__] °C ☐N/K

Any Supplemental Oxygen ☐YES ☐NO ☐N/K **FiO_2 *(0.21-1.0)*** [___].[___][___] or [___][___] % or [___][___] L/min (highest)

Oxygen saturation ☐YES ☐NO ☐N/K **SpO_2** [___][___][___]% (lowest) RR: [___][___]breaths per minute (highest) ☐N/K

AVPU Alert[___] Verbal[___] Pain [___] Unresponsive[___] or ☐N/K Glasgow Coma Score (GCS / 15) [___][___] or ☐N/K

Is the patient currently receiving, or has received (from 00:00 to 24:00) on day of assessment:
Non-invasive respiratory support *(e.g. NIV, BIPAP, CPAP)*? ☐YES ☐NO ☐N/K **Invasive ventilation?** ☐YES ☐NO ☐N/K
High-flow nasal canula? ☐YES ☐NO ☐N/K **ECLS/ECMO?** ☐YES ☐NO ☐N/K

DAILY LABORATORY RESULTS

Record the values of laboratory results taken between 00:00 to 24:00 on day of assessment *(If multiple record the values for the blood draw taken closest to midday)*

Done ☐YES ☐NO ☐N/K **Haemoglobin** _____ ☐g/L *or* ☐g/dL

Done ☐YES ☐NO ☐N/K **WBC count** _____ ☐$x10^9$/L *or* ☐$x10^3$/µL

Done ☐YES ☐NO ☐N/K **Lymphocyte count** _____ ☐cells/µL *or* ☐$x10^9$/L *or* ☐$x10^3$/µL

Done ☐YES ☐NO ☐N/K **Neutrophil count** _____ ☐cells/µL *or* ☐$x10^9$/L *or* ☐$x10^3$/µL

Done ☐YES ☐NO ☐N/K **Platelets** _____ ☐$x10^9$/L *or* ☐$x10^3$/µL

Done ☐YES ☐NO ☐N/K **PT** _____ seconds *or*

Done ☐YES ☐NO ☐N/K **ESR** _____ mm/hr

Done ☐YES ☐NO ☐N/K **Glucose** _____ ☐mmol/L *or* ☐mg/dL

Done ☐YES ☐NO ☐N/K **AST/SGOT** _____ iU/L

Done ☐YES ☐NO ☐N/K **ALT** _____ iU/L

Done ☐YES ☐NO ☐N/K **Blood Urea Nitrogen (urea)** _____ ☐mmol/L *or* ☐mg/dL

Done ☐YES ☐NO ☐N/K **Lactate** _____ ☐mmol/L *or* ☐mg/dL

Done ☐YES ☐NO ☐N/K **LDH** [___][___][___].[___] U/L

Done ☐YES ☐NO ☐N/K **Procalcitonin** [___][___].[___][___]ng/mL

Done ☐YES ☐NO ☐N/K **CRP** [___][___][___].[___] mg/L

Done ☐YES ☐NO ☐N/K eGFR _____ mL/min/1.73 m^2 OCKD-EPI OMDRD OCG

Most recent HbA1c _____ ☐ N/K **date of HbA1c** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Most recent CD4 _____/mm^3 ☐ N/K date of CD4 [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Chest X-Ray /CT performed? ☐YES ☐NO ☐N/K IF Yes: Were infiltrates present? ☐YES ☐NO ☐N/K

ISARIC WHO Clinical Characterisation Protocol

OUTCOME FORM

DIAGNOSTIC TESTING

Was diagnostic testing done during this illness episode? ☐YES ☐NO ☐N/K

Section 1: Diagnosis Summary *(Virus PCR or antigen tests -NOT serology/antibody tests)*			
COVID-19 / SARS-CoV-2	☐ **Tested POSITIVE**	☐ **Tested NEGATIVE**	☐ **NOT TESTED**
Influenza virus *NB: Please do not enter Haemophilus influenza or parainfluenza virus here – enter them under "other" below*	☐ **Tested POSITIVE, please confirm type:** ☐ **A/H3N2** ☐ **A/H1N1pdm09** ☐ **A/H7N9** ☐ **A not typed** ☐ Other A _______________ ☐ **B not typed** ☐ **Other type (specify):** _______________	☐ **Tested NEGATIVE**	☐ **NOT TESTED**
Respiratory syncytial virus	☐ **Tested POSITIVE**	☐ **Tested NEGATIVE**	☐ **NOT TESTED**
Adenovirus	☐ **Tested POSITIVE**	☐ **Tested NEGATIVE**	☐ **NOT TESTED**
Hepatitis viruses	☐ **Tested POSITIVE, please confirm type:** ☐ **A** ☐ **B** ☐ **C** ☐ **D** ☐ **E** ☐ **Other type (specify):** _______________	☐ **Tested NEGATIVE**	☐ **NOT TESTED**
Poisoning	☐ **Tested POSITIVE, please confirm type:** ☐ **Paracetamol** ☐ **Other type (specify):** _______________	☐ **Tested NEGATIVE**	☐ **NOT TESTED**
Monkeypox virus	☐ **Tested POSITIVE**	☐ **Tested NEGATIVE**	☐ **NOT TESTED**
Other	☐ **Tested POSITIVE** **Please specify :** _______________________________		

Section 2: Pathogen Testing Details

(Please record the details of all tests carried out during this illness episode -including the details of the tests indicated above).

Collection Date *(DD/MM/YYYY)*	**Biospecimen Type**	**Result**	**Pathogen Tested/Detected**
_D_ _D_ /_M_ _M_ /202 _Y_	O Nasal/NP swab O Throat swab O Combined nasal/NP + throat swab O Sputum O BAL O ETA O Lesion swab O Urine O Stool/rectal swab O Blood O Other, *Specify:* ___________________	O Positive O Negative O Unknown	______________________
_D_ _D_ /_M_ _M_ /202 _Y_	O Nasal/NP swab O Throat swab O Combined nasal/NP + throat swab O Sputum O BAL O ETA O Lesion swab O Urine O Stool/rectal swab O Blood O Other, *Specify:* ___________________	O Positive O Negative O Unknown	______________________
_D_ _D_ /_M_ _M_ /202 _Y_	O Nasal/NP swab O Throat swab O Combined nasal/NP + throat swab O Sputum O BAL O ETA O Lesion swab O Urine O Stool/rectal swab O Blood O Other, *Specify:* ___________________	O Positive O Negative O Unknown	______________________
_D_ _D_ /_M_ _M_ /202 _Y_	O Nasal/NP swab O Throat swab O Combined nasal/NP + throat swab O Sputum O BAL O ETA O Lesion swab O Urine O Stool/rectal swab O Blood O Other, *Specify:* ___________________	O Positive O Negative O Unknown	______________________

MEDICATION: While being followed, hospitalised or at discharge, were any of the following administered?

Antiviral agent? ☐YES ☐NO ☐N/K If YES, tick all that apply: OCidofovir OBrincidofovir OTecovirimat

ORibavirin OOseltamivir (Tamiflu®) OZanamivir ORemdesivir OOther or novel antiviral _____

Antibiotic? ☐YES ☐NO ☐N/K If YES: specify type(s): _____ _____ _____

Corticosteroid? ☐YES ☐NO ☐N/K

Immunoglobulin? ☐YES ☐NO ☐N/K If YES: specify type: _____

Antifungal agent? ☐YES ☐NO ☐N/K If YES: which _____

Analgesics? ☐YES ☐NO ☐N/K If YES, tick all that apply: OParacetamol ONSAIDs OOpiates OKetamine

Off-label / Compassionate Use medications? ☐YES ☐NO ☐N/K If YES: which _____

TREATMENT: At ANY time during hospitalisation, did the patient receive/undergo:

ICU or High Dependency Unit admission? ☐YES ☐NO ☐N/K **If YES, total duration: _____days O still in ICU/HDU**

If NO, ☐Not indicated ☐Not appropriate*

(*Advanced care plan/discussion documented in notes regarding not for escalation of care beyond ward)

Date of ICU/HDU admission: [_D_][_D_]/[_M_][_M_]/202[_Y_] ☐N/K

ICU/HDU discharge date: [_D_][_D_]/[_M_][_M_]/202[_Y_] ☐N/K

Any Oxygen therapy? ☐YES ☐NO ☐N/K **High-flow nasal canula?** ☐YES ☐NO ☐N/K

Non-invasive ventilation? *(e.g. BIPAP, CPAP)* ☐YES ☐NO ☐N/K

Invasive ventilation *(Any intubation)*? ☐YES ☐NO ☐N/K **If YES, total duration: _____days O still on**

Prone Ventilation? ☐YES ☐NO ☐N/K

Inhaled Nitric Oxide? ☐YES ☐NO ☐N/K

Tracheostomy inserted? ☐YES ☐NO ☐N/K

Extracorporeal (ECMO) support? ☐YES ☐NO ☐N/K **If YES, total duration: _____days O still on**

Renal replacement therapy (RRT) or dialysis? ☐YES ☐NO ☐N/K **If YES, total duration: _____days O still on**

Inotropes/vasopressors? ☐YES ☐NO ☐N/K **If YES, total duration: _____days O still on**

Liver Transplant ☐YES ☐NO ☐N/K **If YES, date** [_D_][_D_]/[_M_][_M_]/ 202[_Y_] ☐N/K

Kidney Transplant ☐YES ☐NO ☐N/K **If YES, date** [_D_][_D_]/[_M_][_M_]/ 202[_Y_] ☐N/K

COMPLICATIONS: At any time during follow-up or hospitalisation did the patient experience: **No complications ☐**			
Viral pneumonia	☐YES ☐NO ☐N/K	Coagulation disorder / Disseminated Intravascular Coagulation	☐YES ☐NO ☐N/K
Bacterial pneumonia	☐YES ☐NO ☐N/K	Deep vein thrombosis	☐YES ☐NO ☐N/K
Acute Respiratory Distress Syndrome	☐YES ☐NO ☐N/K	Pulmonary thromboembolism	☐YES ☐NO ☐N/K
Cryptogenic organizing pneumonia (COP)	☐YES ☐NO ☐N/K	Anaemia	☐YES ☐NO ☐N/K
Pneumothorax	☐YES ☐NO ☐N/K	Rhabdomyolysis / Myositis	☐YES ☐NO ☐N/K
Pleural effusion	☐YES ☐NO ☐N/K	Acute renal injury/acute renal failure	☐YES ☐NO ☐N/K
Bronchiolitis	☐YES ☐NO ☐N/K	Urinary tract infection	☐YES ☐NO ☐N/K
Meningitis / Encephalitis	☐YES ☐NO ☐N/K	Gastrointestinal haemorrhage	☐YES ☐NO ☐N/K
Seizure	☐YES ☐NO ☐N/K	Pancreatitis	☐YES ☐NO ☐N/K
Stroke / Cerebrovascular accident	☐YES ☐NO ☐N/K	Liver dysfunction	☐YES ☐NO ☐N/K
Other neurological complication	☐YES ☐NO ☐N/K	Hyperglycaemia	☐YES ☐NO ☐N/K
Congestive heart failure	☐YES ☐NO ☐N/K	Hypoglycaemia	☐YES ☐NO ☐N/K
Endocarditis	☐YES ☐NO ☐N/K	Bacteraemia	☐YES ☐NO ☐N/K
Myocarditis/Pericarditis	☐YES ☐NO ☐N/K	Cellulitis	☐YES ☐NO ☐N/K
Cardiomyopathy	☐YES ☐NO ☐N/K	Skin abscess	☐YES ☐NO ☐N/K
Cardiac arrhythmia	☐YES ☐NO ☐N/K	Skin tissue loss or eschar	☐YES ☐NO ☐N/K
Cardiac ischemia	☐YES ☐NO ☐N/K	Other complication(s)	☐YES ☐NO ☐N/K
Cardiac arrest	☐YES ☐NO ☐N/K	If yes, specify other:	

OUTCOME: (complete at discharge, transfer death or DAY 28, whichever occurs first)

Outcome: ☐ **Discharged (or not admitted) alive expected to survive**

☐ **Hospitalisation = Remains in Hospital ≥ Day 28 after symptom onset**

- if Hospitalisation ☐ **Ongoing health care needs relating to this admission**

OR

☐ **Ongoing health care needs NOT related to this episode**

OR

☐ **Medically fit for discharge but remains in hospital for other reason**

(e.g. awaiting suitable care in community, resident in long term health care or mental health facility)

☐ **Transfer to other facility** ☐ **Palliative discharge** ☐ **Death** ☐ **N/K**

Outcome date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_] ☐ **N/K**

If Discharged alive:

Ability to self-care at discharge versus before illness: ☐ Same as before illness ☐ Worse ☐ Better ☐ N/K

If Discharged alive: Post-discharge treatment:

Oxygen therapy? ☐ YES ☐ NO ☐ N/K

If Transferred: Facility name: _____ ☐ N/K

If Transferred: Is the transfer facility a study site? ☐ YES ☐ NO ☐ N/K

If a Study Site: Participant ID # at new facility: ☐ Same as above

☐ Different: [___][___][___][___][___]- [___][___][___][___] ☐N/K

PREGNANCY OUTCOME: If delivered during admission, please confirm:

POST PARTUM (within six weeks of delivery)? ☐YES ☐NO or ☐N/K

Pregnancy Outcome: ☐Live birth ☐Still birth Delivery date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_2_][_Y_]

Has infant(s) been tested for Mother's infection? ☐YES ☐NO ☐N/K If YES: ☐Positive ☐Negative

IF POSITIVE PLEASE COMPLETE A SEPARATE CASE REPORT FORM FOR THE INFANT(s)

PAEDIATRIC HEPATITIS MODULE

Complete this module at admission

Additional Recent Illness History

In the last 3 months, has your child had a diarrhoea and vomiting / gastroenteritis illness? ☐YES ☐NO ☐N/K

If yes, approximate date of this illness: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

If yes, did these symptoms persist for more than a week? ☐YES ☐NO ☐N/K

If yes, what persistent symptoms did they have in the last three months?

History of fever **☐YES ☐NO ☐N/K.** Vomiting / Nausea **☐YES ☐NO ☐N/K**

Diarrhoea **☐YES ☐NO ☐N/K** Abdominal pain **☐YES ☐NO ☐N/K**

Weight loss **☐YES ☐NO ☐N/K** Tiredness **☐YES ☐NO ☐N/K**

Other (free text) _____

MONKEYPOX MODULE

Complete this module at admission and daily during hospital admission

DAILY SIGNS AND SYMPTOMS			None (asymptomatic) ☐
Sore throat	☐YES ☐NO ☐N/K	**Keratitis**	☐YES ☐NO ☐N/K
Lower respiratory tract symptoms (productive cough, wheezing, respiratory distress)	☐YES ☐NO ☐N/K	**Conjunctivitis**	☐YES ☐NO ☐N/K
		Pruritis	☐YES ☐NO ☐N/K
Muscle aches (Myalgia)	☐YES ☐NO ☐N/K	**Lymphadenopathy**	☐YES ☐NO ☐N/K
Joint pain (Arthralgia)	☐YES ☐NO ☐N/K	**If yes, Painful lymph nodes**	☐YES ☐NO ☐N/K
Weight loss	☐YES ☐NO ☐N/K	**If yes, Axillary (arm pits)**	☐YES ☐NO ☐N/K
Vomiting / Nausea	☐YES ☐NO ☐N/K	**If yes, Cervical (neck)**	☐YES ☐NO ☐N/K
Diarrhoea	☐YES ☐NO ☐N/K	**If yes, Inguinal (groin)**	☐YES ☐NO ☐N/K
Abdominal pain	☐YES ☐NO ☐N/K	**If yes, Other site**	☐YES ☐NO ☐N/K
Constipation	☐YES ☐NO ☐N/K	**Specify site:**	_____
Urinary retention	☐YES ☐NO ☐N/K	**Bleeding (Haemorrhage)**	☐YES ☐NO ☐N/K
Jaundice	☐YES ☐NO ☐N/K	**If bleeding, specify site(s)**	_____
Fatigue / Malaise	☐YES ☐NO ☐N/K	**Other symptom(s)**	☐YES ☐NO ☐N/K
Headache	☐YES ☐NO ☐N/K	**If yes, specify other:**	_____
Altered consciousness/confusion	☐YES ☐NO ☐N/K		
Psychological disturbance	☐YES ☐NO ☐N/K		
Seizures	☐YES ☐NO ☐N/K		

DAILY LESION ASSESSMENT

Have new lesions appeared in the previous 24 hours? (patients may be best placed to assess this) ☐YES ☐NO ☐N/K

Estimate total number of lesions on the body: ☐None ☐1-5 ☐6-25 ☐26-100 ☐ >100 ☐N/K

Are there active lesions in the following areas?

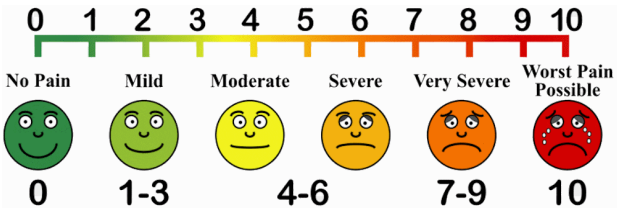
Head, face, neck	☐YES ☐NO ☐N/K	External genitalia	☐YES ☐NO ☐N/K
Inside of mouth	☐YES ☐NO ☐N/K	Perianal	☐YES ☐NO ☐N/K
Torso	☐YES ☐NO ☐N/K	Vaginal canal	☐YES ☐NO ☐N/K
Arms and/or hands	☐YES ☐NO ☐N/K	Rectum	☐YES ☐NO ☐N/K
Legs and/or feet	☐YES ☐NO ☐N/K	Other	☐YES ☐NO ☐N/K
		Specify where:	_____

Are these types of lesions on the body today?

Vesicle	☐YES ☐NO ☐N/K	Crusted/scabbed mature lesion	☐YES ☐NO ☐N/K
Pustule	☐YES ☐NO ☐N/K	Residual evidence of resolved lesions (scar/discoloration)	☐YES ☐NO ☐N/K
Ulcerated lesion	☐YES ☐NO ☐N/K	Haemorrhagic / bleeding lesions	☐YES ☐NO ☐N/K

Pain at lesion site: ☐YES ☐NO ☐N/K

If yes, score: [___] [___]/10 where zero means "no pain," and 10 means "the worst possible pain."



Describe any other lesion complications: _____