MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

CLINICAL INCLUSION CRITERIA

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

DEMOGRAPHICS

Clinical centre name:_____ **Country:**_____

Enrolment date /first COVID-19 assessment date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

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

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

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

Pregnant? O YES O NO O Unknown **If YES: Gestational weeks assessment:** [___][___] weeks

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

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

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

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

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

Birth weight: [___][___].[___] O kg or O lbs O Unknown

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

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

Vaccinations appropriate for age/country? O YES O NO O Unknown

ONSET & ADMISSION

Onset date of first/earliest symptom: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Most recent presentation/admission date at this facility: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

RE-ADMISSION

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

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

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

If YES, Participant Identification number (PIN): _____

Is the patient being re-admitted with or due to COVID-19? ***(Please only add re-admission episodes for COVID related complications or patients remaining positive). Assign new subject ID*** O YES O NO O Unknown

Previous participant ID: _____ O Unknown

Number of re-admissions: _____ **(record as a new patient for each re-admission)**

Please provide reason for readmission: _____

MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

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

Temperature: [____][____][____].[____]O°C *or* O°F

HR: [____][____][____]beats/minute **RR:** [____][____]breaths/minute

Systolic BP: [___][___][___]mmHg **Diastolic BP:** [____][____][____]mmHg

Oxygen saturation: [___][___][___]% **On:** ORoom air OOxygen therapy OUnknown

Sternal capillary refill time >2sec. OYES ONO OUnknown **Height:** [___][___][___]cm **Weight:** [___][___][___]kg

SIGNS AND SYMPTOMS ON ADMISSION *(Unk = Unknown)*

History of fever	OYES ONO OUnk	Fatigue / Malaise	OYES ONO OUnk
Cough OYES - non-productive OYES - productive OYES - with haemoptysis ONO OUnk		Anorexia	OYES ONO OUnk
		Altered consciousness/confusion	OYES ONO OUnk
Sore throat	OYES ONO OUnk	Muscle aches (myalgia)	OYES ONO OUnk
Runny nose (rhinorrhoea)	OYES ONO OUnk	Joint pain (arthralgia)	OYES ONO OUnk
Wheezing	OYES ONO OUnk	Inability to walk	OYES ONO OUnk
Shortness of breath	OYES ONO OUnk	Abdominal pain	OYES ONO OUnk
Lower chest wall indrawing	OYES ONO OUnk	Diarrhoea	OYES ONO OUnk
Chest pain	OYES ONO OUnk	Vomiting / Nausea	OYES ONO OUnk
Conjunctivitis	OYES ONO OUnk	Skin rash	OYES ONO OUnk
Lymphadenopathy	OYES ONO OUnk	Bleeding (Haemorrhage) OYES ONO OUnk If YES, specify site(s):_____	
Headache	OYES ONO OUnk		
Loss of smell (Anosmia)	OYES ONO OUnk	Other symptom(s) OYES ONO OUnk If YES, specify:_____	
Loss of taste (Ageusia)	OYES ONO OUnk		
Seizures	OYES ONO OUnk		

VACCINATIONS

Covid-19 vaccination: OYES ONO OUnk

Date of first vaccine :[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date: Oactual Oestimated

Type of first vaccine: OPfizer/BioNTech |OAstraZeneca Oxford (Covishield in India) |OModerna |ONovavax
OJanssens (Johnson & Johnson) |OSinopharm |OSinovac |OSputnik V |OCovaxin |OCanSinoBIO
OUnknown |Oother, please specify _____

Date of second vaccine :[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date: Oactual Oestimated

Type of second vaccine: OPfizer/BioNTech |OAstraZeneca/University of Oxford (Covishield in India) |OModerna |ONovavax
OJanssens (Johnson & Johnson) |OSinopharm |OSinovac |OSputnik V |OCovaxin |OCanSinoBIO
OUnknown |Oother, please specify _____

Date of third vaccine :[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date: Oactual Oestimated

Type of third vaccine: OPfizer/BioNTech |OAstraZeneca/University of Oxford (Covishield in India) |OModerna |ONovavax
OJanssens (Johnson & Johnson) |OSinopharm |OSinovac |OSputnik V |OCovaxin |OCanSinoBIO
OUnknown |Oother, please specify _____

Influenza vaccination within the last 6 months: OYES ONO OUnknown

Date of influenza vaccine :[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date: Oactual Oestimated

MODULE 1: PRESENTATION/ADMISSION CASE REPORT FORM

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

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