Protocol for assessment of potential risk factors for coronavirus disease 2019 (COVID-19) among health workers in a health care setting

Form 2: Follow-up reporting form for health worker (Day > 21)

Unique ID/Cluster number (if applicable):

1. Current status
□ Alive □ Dead □ Unknown/lost to follow-up

2. Health worker pre-existing condition(s)	
Pregnancy	□ Yes □ No □ Unknown If Yes, specify trimester: □ First □ Second □ Third □ Unknown

3a. Health worker symptoms	
Have you experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period since the baseline visit and specimen collection?	□ Yes □ No If no, please move on to section 3c
If yes, date of first symptom onset (dd/mm/yyyy)	___/___/___ □ Unknown
Fever (≥ 38 °C) or history of fever	□ Yes □ No □ Unknown If Yes, date ___/___/___ If yes, specify maximum temperature:
3b. Respiratory symptoms	
Sore throat	□ Yes □ No □ Unknown
Cough	□ Yes □ No □ Unknown
Runny nose	□ Yes □ No □ Unknown
Shortness of breath	□ Yes □ No □ Unknown
3c. Other symptoms	
Chills	□ Yes □ No □ Unknown
Vomiting	□ Yes □ No □ Unknown
Nausea	□ Yes □ No □ Unknown
Diarrhoea	□ Yes □ No □ Unknown
Headache	□ Yes □ No □ Unknown
Rash	□ Yes □ No □ Unknown

Conjunctivitis	□ Yes □ No □ Unknown
Muscle aches	□ Yes □ No □ Unknown
Joint ache	□ Yes □ No □ Unknown
Loss of appetite	□ Yes □ No □ Unknown
Loss of smell (anosmia) or taste	□ Yes □ No □ Unknown
Nose bleed	□ Yes □ No □ Unknown
Fatigue	□ Yes □ No □ Unknown
Seizures	□ Yes □ No □ Unknown
Altered consciousness	□ Yes □ No □ Unknown
Other neurological signs	□ Yes □ No □ Unknown If Yes, specify:
Other symptoms	□ Yes □ No □ Unknown If yes, specify:

The following part will be filled out **by study coordinator or equivalent**

4a. Laboratory: Serology testing methods and results:							
Complete a new line for each specimen collected and each type of test done:							
Laboratory identification number	**Date sample collected (dd/mm/yyyy)**	**Date sample received (dd/mm/yyyy)**	**Type of sample**	**Type of test**	**Result (COVID-19 antibody titres)**	**Result date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Serum □ Other, specify:	Specify type (ELISA/IFA IgM/IgG, neutralization assay, etc.):	□ POSITIVE If positive, titre: □ NEGATIVE □ INCONCLUSIVE	___/___/___	□ Yes If Yes, specify date ___/___/___ If Yes, name of the laboratory: □ No

4b. Laboratory: Virology testing methods and results (OPTIONNAL)							
Complete a new line for each specimen collected and each type of test done:							
Laboratory identification number	**Date sample collected (dd/mm/yyyy)**	**Date sample received (dd/mm/yyyy)**	**Type of sample**	**Type of test**	**Result**	**Result date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Nasal swab □ Throat swab □ Nasopharyngeal swab □ Other, specify:	□ PCR □ Whole genome sequencing □ Partial genome sequencing □ Other, specify	□ POSITIVE for COVID-19 □ NEGATIVE for COVID-19 □ POSITIVE for other pathogens Please specify which pathogens:	___/___/___	□ Yes If Yes, specify date ___/___/___ If Yes, name of the laboratory: □ No

5. Status of form completion	
Form completed	□ Yes □ No or partially If No or partially, reason: □ Missed □ Not attempted □ Not performed □ Refusal □ Other, specify:

6. Outcome (Day > 21)	
Outcome	□ Alive □ Died □ NA □ Unknown If dead, cause:
Outcome current as of date (dd/mm/yyyy)	___/___/___ □ Unknown □ NA
Hospitalization	□ Yes □ No □ Unknown If yes, date of first hospitalization ___/___/___ □ Unknown If yes, reason for hospitalization:

Module extracted from pages 32-35 (section "Form 2: Follow-up reporting form for health worker (Day > 21)") from the full survey "Protocol for assessment of potential risk factors for coronavirus disease 2019 (COVID-19) among health workers in a health care setting"