CASE RECORD FORM INSTRUCTIONS

SEVERE ACUTE RESPIRATORY INFECTION NATURAL HISTORY & BIOLOGICAL SAMPLING STUDY

DESIGN OF THIS CASE RECORD FORM (CRF)

This CRF is divided into 4 main forms: a "RAPID" (page 1) form with basic admission and outcome data; a "CORE" form with more detailed presentation (pages 2-3) and outcome (pages 4-6) data; a "DAILY" form (page 7) for daily laboratory and clinical data; and a set of "SUPPLEMENTAL" (Page 8-13) forms for overflow data and other investigations. These forms should be used in one of the defined combinations below according to the site's resource availability and scientific interests.

HOW TO USE THIS CRF

Each site may choose the amount of data to collect based on available resources and the number of patients enrolled to date. Ideally, data on patients presenting early in an outbreak will be collected using the Tier 2 combination and schedule of forms outlined below. Sites without the capacity to collect the periodic daily data requested in Tier 2, or who have already collected large numbers of Tier 2 patient data may choose the Tier 1 collection, which includes admission (Day 1) and outcome data only. Sites with very low resources or very high patient numbers may select Tier 0. The decision is up to the site Investigators and may be changed throughout the data collection period. All high quality data is valuable for analysis.

Tier 0 – **Complete the 1-page RAPID CRF for each patient** – For low resource sites or sites that have already enrolled large numbers of patients on Tier 1/2 collection.

Tier 1 – **Complete the RAPID CRF, CORE CRF and DAILY CRF on Day 1 only for each patient. –** For sites that do not have the resources to collect the additional daily data included in Tier 2.

Tier 2 - **Complete the RAPID CRF, CORE CRF and DAILY CRF on Days 1 & 2 of hospital admission*, Days 1 & 2 of ICU admission* (if applicable) and each day that biological samples are taken for research purposes.** – For patients who present early in the outbreak or sites with available resources.

**Note that Day 1 & 2 of hospital admission and/or Day 1 & 2 of ICU admission may be retrospective data if the patient is enrolled after the admission date.*

Tier 3 – Analysis modules that address specific additional scientific questions (e.g. epidemiology). These may be completed in addition to the Tier chosen **according to the scientific interests of the site**. If you would like to suggest a new module for inclusion in these forms please contact us at the email below.

GENERAL GUIDANCE

- The CRF is designed to collect data obtained through patient examination, patient interview and review of hospital notes.
- Patient numbers consist of a 3-digit site code and a 4 digit patient number. You can obtain a site code by registering on the data management system at https://www.cliresdms.org. Patient numbers should be assigned sequentially for each site beginning with 0001. In the case of a single site recruiting patients on different wards, or where it is otherwise difficult to assign sequential numbers, it is acceptable to assign numbers in blocks. E.g. Out-patient ward will assign numbers from 0001 onwards. In-patient ward will assign numbers from 5001 onwards. Alpha characters can also be used. E.g. Out-patient ward will assign A001 onwards. In-patient ward will assign B001 onwards. Please enter the patient identification code at the top of each and every sheet.
- Complete every line of every section, except for where the instructions say to skip a section based on certain responses.
- 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).
- It is important to know when the answer to a particular question is not known. Please mark the 'Unknown' box if this is the case. If an 'Unknown' box is not shown, please see the CRF Completion Guidelines for further guidance. For laboratory values, please enter "NA" in the data space when results are Not Available.
- Some sections have open areas where you can write in additional information. To permit standardised data entry, please avoid writing additional information outside of these areas.
- We recommend writing clearly in black or blue 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 patient together e.g. with a staple or in a folder that is unique to the patient.
- Please enter data on the electronic data capture system at https://www.cliresdms.org. If your site would like to collect data independently, we are happy to support the establishment of local databases (see contact below).
- Please contact us at isaric@oucru.org if we can help with databases, if you have comments and to let us know that you are using the forms.

RAPID CASE RECORD FORM - Severe Acute Respiratory Infection

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) **[__][__][__] – [__][__][__][__]**

This is the 1-page (Tier 0) RAPID clinical data set. Please complete for ALL patients. Complete sections 1-4 at admission. Complete section 5 upon ICU admission (if applicable). Complete section 6 after discharge/death. Enter data to the online database at https://www.clinresdms.org

1. SITE

Clinical centre:_____ **Country**: _____

Date of patient enrolment: *(DD/MM/YYYY):* [____][____]/[____][____]/[__2_][__0_][____][____]

2. DEMOGRAPHICS

Sex at Birth: ☐Male ☐Female **Date of birth** *(DD/MM/YYYY):* [____][____]/[____][____]/[____][____][____][____]

If date of birth unknown: Estimated age [___][___][___]years OR [___][___]months

Pregnant? ☐YES ☐NO ☐Unknown ☐Not Applicable **If YES: Gestation age of fetus** *(nearest week)*: [___][___]

3. INFECTIOUS RESPIRATORY DIAGNOSIS

Influenza: ☐ YES- Confirmed ☐YES- Probable ☐NO **If** YES: ☐H7N9 ☐H5N1 ☐Other: _____

Coronavirus: ☐YES- Confirmed ☐YES- Probable ☐NO **If** YES: ☐MERS-CoV ☐Other: _____

Other: ☐YES- Confirmed ☐YES- Probable ☐NO **If** YES: ☐Other: _____

Unknown: ☐

4. ONSET & ADMISSION

Date of onset of first/earliest symptom *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____]

Date of admission to this hospital (*DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____]

5. INTENSIVE CARE OR HIGH DEPENDENCY CARE UNIT ADMISSION

Admitted to ICU (or high dependency unit)? ☐YES *(complete the rest of this section)* ☐NO *(skip the rest of section 6)*

Date of ICU admission (*DD/MM/YYYY*): [____][____]/[____][____]/[__2__][__0__][____][____]

Record most abnormal value in first 24 hours of ICU admission *(Mark units if choice is given. If Not Available write "NA")*:

Mechanical ventilation ☐YES ☐NO

FiO_2 *(0.21-1.0):* [___].[___][___] or [___][___]L/min **PaO_2** [___][___][___]☐kPa *or* ☐mmHg or **SaO_2**:[___][___][___]%

Platelet Count [___][___][___][___]x10 9/L **Bilirubin** [___][___][___]µmol/L

Creatinine [___][___][___][___]☐µmol/L *or* ☐mg/dL **Mean arterial pressure** [___][___][___]mmHg

Glasgow Coma Score *(out of 15)*: [___][___] **Urine output** [___][___][___][___]mL/24 hours ☐Check if estimated

Any vasopressor/inotropic support on 1st day of ICU admission? ☐YES ☐NO (if NO, answer the next 3 questions NO)

Dopamine <5µg/kg/min OR Dobutamine OR Milrinone OR Levosimendan: ☐YES ☐NO

Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine: ☐YES ☐NO

Dopamine >15µg/k/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: ☐YES ☐NO

Date of ICU discharge (*DD/MM/YYYY*): [____][____]/[____][____]/[__2__][__0__][____][____] **Discharge status:** ☐Alive ☐Dead

6. OUTCOME

CORE CASE RECORD FORM - Severe Acute Respiratory Infection

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

During hospital admission did the patient at *any* time receive:

Supplemental O_2: ☐YES ☐NO **Invasive ventilation** ☐YES ☐NO **Non-invasive ventilation:** ☐YES ☐NO

ECMO/ECLS: ☐YES ☐NO **Dialysis:** ☐YES ☐NO

Final Outcome: ☐Discharged alive ☐Still in hospital ☐Transferred to other facility ☐Died ☐Palliative discharge ☐Unknown

Date of final outcome (*DD/MM/YYYY*): [____][____]/[____][____]/[__2__][__0__][____][____]

Complete sections 1-3 at admission (Tier 1 & Tier 2). Enter data to the online database at https://www.cliresdms.org

1. DEMOGRAPHICS

Weight on admission *(whole number)* [__][__][__]☐kg *or* ☐lbs ☐Unknown **Height**: [__][__][__]☐cm *or* ☐inches ☐Unknown

If age <5 years: Mid-upper-arm circumference [__][__][__]mm ☐Unknown/Not applicable

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

Transferred from another facility? ☐YES ☐NO ☐Unknown If YES: **Name of transferring facility**:_____

If YES: **Date admitted** to other facility *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Did the patient travel in the 14 days prior to first symptom onset? ☐YES ☐NO ☐Unknown

If YES, *state location(s) & date(s):* Country:_____ City/Region: _____

Return Date *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown
(more space is available on the SUPPLEMENTARY DATA FORM – CORE – SECTION 1 – TRAVEL)

Did the patient have contact with live/dead animals, raw meat or insect bites in the 14 days prior to first symptom onset?
☐YES ☐NO ☐Unknown *If YES, complete the CORE – SECTION 1 - ANIMAL EXPOSURE section of the SUPPLEMENTARY DATA FORM.*

2. CO-MORBIDITIES & RISK FACTORS *(existing PRIOR TO ADMISSION & that are active problems)* *(Charlson Index will be calculated at analysis)*

Chronic cardiac disease	☐YES ☐NO ☐Unknown	Metastatic solid tumour	☐YES ☐NO ☐Unknown
Chronic pulmonary disease *(not asthma)*	☐YES ☐NO ☐Unknown	Any malignancy including leukaemia & lymphoma	☐YES ☐NO ☐Unknown
Physician diagnosed asthma	☐YES ☐NO ☐Unknown	AIDS / HIV	☐YES ☐NO ☐Unknown
Renal disease	☐YES ☐NO ☐Unknown	Obese as defined by clinical staff	☐YES ☐NO ☐Unknown
Moderate or severe liver disease	☐YES ☐NO ☐Unknown	Diabetes with chronic complications	☐YES ☐NO ☐Unknown
Mild liver disease	☐YES ☐NO ☐Unknown	Rheumatologic disease	☐YES ☐NO ☐Unknown
Chronic neurological disease	☐YES ☐NO ☐Unknown	Dementia	☐YES ☐NO ☐Unknown
Hemiplegia or paraplegia	☐YES ☐NO ☐Unknown		

History of recurrent fever prior to admission? ☐Yes ☐No ☐Unknown

Proven malaria since onset of symptoms? ☐YES ☐NO ☐Unknown

Receiving immunosuppressants (including inhaled/oral corticosteroids) prior to admission? ☐YES ☐NO ☐Unknown
If YES, complete the CORE – SECTION 2 - ADMISSION IMMUNOSUPPRESSANTS section of the SUPPLEMENTARY DATA FORM.

Treated with anti-infectives for this illness episode prior to admission? ☐YES ☐NO ☐Unknown
If YES, complete the CORE – SECTION 2 - ADMISSION ANTI-INFECTIVES section of the SUPPLEMENTARY DATA FORM.

POST PARTUM? ☐YES ☐NO or Not Applicable *(skip this section - go to INFANT)* **Pregnancy Outcome:** ☐Live birth ☐Still birth

Delivery date *(DD/MM/YYYY)* [____][____]/[____][____]/[__2__][__0__][____][____]

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PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

Baby tested for Mom's infection? ☐YES ☐NO ☐Unknown **If YES:** ☐Positive ☐Negative **Method:** ☐PCR ☐Other:_____

INFANT – Less than 1 year old? ☐YES ☐NO *(skip this section)* **Birth weight if known:** [___][___].[___]☐kg or ☐lbs ☐Unknown

Gestation: ☐ Term-born (≥37wk GA) ☐Preterm(<37wk GA) ☐Unknown

Breastfed? ☐YES ☐NO ☐Unknown **If YES:** ☐Still breastfeeding ☐Discontinued at [___][___] weeks

Development appropriate for age? ☐YES ☐NO ☐Unknown **Vaccinations appropriate for age/country?** ☐YES ☐NO ☐Unknown

Any other risk factor(s) considered relevant:_____

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

Temperature: [___][___][___].[___]☐°C *or* ☐°F **HR:** [___][___][___]beats per minute **RR:** [___][___]breaths per minute

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

Severe dehydration? ☐YES ☐NO ☐Unknown **Sternal capillary refill time >2secs?** ☐YES ☐NO ☐Unknown

O_2 saturation: [___][___][___]% **On:** ☐Room air ☐Supplemental O_2 ☐Unknown

Admission signs and symptoms *(observed/reported at admission and associated with this episode of acute illness)*

History of fever (>38°C)	☐YES ☐NO ☐Unknown	Lower chest wall indrawing	☐YES ☐NO ☐Unknown
Cough	☐YES ☐NO ☐Unknown	Headache	☐YES ☐NO ☐Unknown
with sputum production	☐YES ☐NO ☐Unknown	Altered consciousness/confusion	☐YES ☐NO ☐Unknown
bloody sputum/haemoptysis	☐YES ☐NO ☐Unknown	Seizures	☐YES ☐NO ☐Unknown
Sore throat	☐YES ☐NO ☐Unknown	Abdominal pain	☐YES ☐NO ☐Unknown
Runny nose (rhinorrhoea)	☐YES ☐NO ☐Unknown	Vomiting/nausea	☐YES ☐NO ☐Unknown
Ear ache	☐YES ☐NO ☐Unknown	Diarrhoea	☐YES ☐NO ☐Unknown
Wheezing	☐YES ☐NO ☐Unknown	Conjunctivitis	☐YES ☐NO ☐Unknown
Chest pain	☐YES ☐NO ☐Unknown	Skin rash	☐YES ☐NO ☐Unknown
Muscle aches (myalgia)	☐YES ☐NO ☐Unknown	Skin ulcers	☐YES ☐NO ☐Unknown
Joint pain (arthralgia)	☐YES ☐NO ☐Unknown	Lymphadenopathy	☐YES ☐NO ☐Unknown
Fatigue/malaise	☐YES ☐NO ☐Unknown	Bleeding	☐YES ☐NO ☐Unknown
Shortness of breath	☐YES ☐NO ☐Unknown	If bleeding, specify site:	_____

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PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

Complete OUTCOME sections 4-9 after discharge/death. Additional information can be recorded on the SUPPLEMENTARY DATA FORM. Daily information is recorded on the DAILY RECORD FORM.

4. COMPLICATIONS: At any time during hospitalisation did the patient experience *(complete every line)*:			
Viral pneumonitis	☐YES ☐NO ☐Unknown	Cardiac arrest	☐YES ☐NO ☐Unknown
Bacterial pneumonia	☐YES ☐NO ☐Unknown	Bacteraemia	☐YES ☐NO ☐Unknown
Acute lung injury / ARDS	☐YES ☐NO ☐Unknown	Coagulopathy or DIC	☐YES ☐NO ☐Unknown
Pneumothorax	☐YES ☐NO ☐Unknown	Anaemia	☐YES ☐NO ☐Unknown
Pleural effusion	☐YES ☐NO ☐Unknown	Rhabdomyolysis or myositis	☐YES ☐NO ☐Unknown
Bronchiolitis	☐YES ☐NO ☐Unknown	Acute renal injury/failure	☐YES ☐NO ☐Unknown
Meningitis/Encephalitis	☐YES ☐NO ☐Unknown	Gastrointestinal bleeding	☐YES ☐NO ☐Unknown
Seizure(s)	☐YES ☐NO ☐Unknown	Pancreatitis	☐YES ☐NO ☐Unknown
Stroke	☐YES ☐NO ☐Unknown	Hepatic dysfunction	☐YES ☐NO ☐Unknown
Congestive heart failure	☐YES ☐NO ☐Unknown	Hyperglycemia	☐YES ☐NO ☐Unknown
Endo/myo/peri-carditis	☐YES ☐NO ☐Unknown	Hypoglycemia	☐YES ☐NO ☐Unknown
Cardiac arrhythmia	☐YES ☐NO ☐Unknown	Other	☐YES ☐NO ☐Unknown
Cardiac ischaemia	☐YES ☐NO ☐Unknown	*Specify:* _____	

5. PATHOGEN TESTING: *(more space is available on the SUPPLEMENTARY DATA FORM – CORE – SECTION 5 – PATHOGEN TESTING)*
Was pathogen testing performed during this illness episode? ☐YES *(complete below)* ☐NO ☐Unknown

Sample Collection Date *(DD/MM/YYYY)*	**Sample Type**	**Method**	**Result**	**Pathogen Tested**
__ __/__ __/20__ __	**Nasal/NP swab**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Throat swab**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Combined nasal/NP + Throat swab**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Sputum**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Broncho-alveolar lavage (BAL)**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Endotracheal aspirate (ETA)**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Stool/Rectal swab**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Urine**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Blood**	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____
__ __/__ __/20__ __	**Other (specify):** _____	☐PCR ☐Culture ☐Other_____	☐Positive ☐Unknown ☐Negative	*Specify:* _____

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PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

6. OTHER INFECTIONS: Did the patient test positive for any other infection? ☐YES ☐NO ☐Unknown *If YES, specify.*
(more space is available on the SUPPLEMENTARY DATA FORM – CORE – SECTION 6 – OTHER INFECTIONS)

Sample/Detection Date *(DD/MM/YYYY)*	**Sample Type** *(choose from list in #5 above)*	**Type of Infection**	**Pathogen**
____/____/20____	*Specify:* _____	☐ Bacterial ☐ Viral ☐ Fungal ☐ Other:_____	*Specify:* _____
____/____/20____	*Specify:* _____	☐ Bacterial ☐ Viral ☐ Fungal ☐ Other:_____	*Specify:* _____
____/____/20____	*Specify:* _____	☐ Bacterial ☐ Viral ☐ Fungal ☐ Other:_____	*Specify:* _____
____/____/20____	*Specify:* _____	☐ Bacterial ☐ Viral ☐ Fungal ☐ Other:_____	*Specify:* _____

7. TREATMENT: At ANY time during hospitalisation, did the patient receive *(please complete every line)*

Supplemental oxygen? ☐YES ☐NO ☐Unknown ..... If YES, total duration: _____days

If YES: First day *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Last day *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Non-invasive mechanical ventilation? (e.g. BIPAP, CPAP) ☐YES ☐NO ☐Unknown..... If YES, total duration: _____ days

Invasive mechanical ventilation (Any)? ☐YES ☐NO ☐Unknown ..... If YES, total duration: _____days

If YES: First day *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Last day *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Oscillatory Ventilation? ☐YES ☐NO ☐Unknown ..... If YES, total duration: _____days

Prone Ventilation? ☐YES ☐NO ☐Unknown ..... If YES, total duration: _____days

Inhaled Nitric Oxide? ☐YES ☐NO ☐Unknown ..... If YES, total duration: _____days

Extracorporeal membrane oxygenation (ECMO) or interventional lung-assist therapy (iLA)?

☐ECMO ☐iLA ☐None ☐Unknown ☐Not available at site..... If YES, total duration: _____ days

If YES: First day *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Last day *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Renal replacement therapy (RRT) or dialysis? ☐YES ☐NO ☐Unknown..... If YES, total duration: _____ days

If YES: First day *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Last day *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Inotropes/vasopressors? ☐YES ☐NO ☐Unknown ..... If YES, total duration: _____days

If YES: First day *(DD/MM/YYYY)*: [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Last day *(DD/MM/YYYY):* [____][____]/[____][____]/[__2__][__0__][____][____] ☐Unknown

Plasmapheresis/exchange? ☐YES ☐NO ☐Unknown **Oral rehydration therapy?** ☐YES ☐NO ☐Unknown

Intravenous Immunoglobulin? ☐YES ☐NO ☐Unknown **Blood transfusion or products?** ☐YES ☐NO ☐Unknown

OTHER intervention *(please specify)*: _____
_____

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

8. MEDICATION: While hospitalised or at discharge, were any of the following administered?

Antivirals? ☐YES ☐NO ☐Unknown If YES: ○Neuraminidase Inhibitors ○Other **Antibiotics?** ☐YES ☐NO ☐Unknown

Corticosteroids? ☐YES ☐NO ☐Unknown If YES: ○Oral ○Intravenous ○Inhaled **Antifungals?** ☐YES ☐NO ☐Unknown

If any of the anti-infectives or corticosteroids listed above were administered, please complete the MEDICATION: ANTI-INFECTIVES & CORTICOSTEROIDS section of the SUPPLEMENTAL DATA FORM.

Angiotensin converting enzyme inhibitors (ACE-Is) or angiotensin receptor blockers (ARBs)? ☐YES ☐NO ☐Unknown

Statins? ☐YES ☐NO ☐Unknown **If YES, was the patient taking statins prior to admission?** ☐YES ☐NO ☐Unknown

9. OUTCOME

Transferred to another facility: ☐YES ☐NO ☐Unknown

If **YES**, name of new facility: _____ ☐Unknown

Discharged from hospital care: ☐YES ☐NO ☐Unknown *(If NO, skip the next 2 questions)*

If **YES,** ability to self-care at discharge versus prior to illness: ☐Same as prior to illness ☐ Worse ☐ Better ☐Unknown

If **YES,** post-discharge treatment**:**

Supplemental oxygen? ☐YES ☐NO ☐Unknown **Dialysis/renal treatment?** ☐YES ☐NO ☐Unknown

Other Treatment? ☐YES ☐NO ☐Unknown If YES, specify *(multiple permitted):*_____

Deceased? ☐YES ☐NO ☐Unknown

If **YES,** primary cause of death *(one only)*:

☐Multi-organ dysfunction syndrome ☐Acute lung injury ☐Pneumonia ☐Myocardial infarction

☐Congestive heart failure ☐Dysrhythmia ☐Chronic obstructive lung disease ☐Pulmonary emboli

☐Cerebrovascular disease ☐Renal failure ☐Liver failure ☐Malignancy

☐Other, specify: _____

If **YES,** contributory cause(s) of death *(check all that apply)*:

○Multi-organ dysfunction syndrome ○Acute lung injury ○Pneumonia ○Myocardial infarction

○Congestive heart failure ○Dysrhythmia ○Chronic obstructive lung disease ○Pulmonary emboli

○Cerebrovascular disease ○Renal failure ○Liver failure ○Malignancy

○Other, specify: _____ ○Other, specify: _____

Final diagnoses during hospital admission (check/complete all that apply)**:**

○H7N9 ○H5N1 ○MERS-CoV

○Other, specify: _____

○Other, specify: _____

○Other, specify: _____

○Other, specify: _____

○Other, specify: _____

(more space is available on the SUPPLEMENTARY DATA FORM – CORE – ADDITIONAL INFORMATION)

DAILY CASE RECORD FORM - Severe Acute Respiratory Infection

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) **[__][__][__] - [__][__][__][__]**

Tier 1 - complete form on Day 1 of hospital admission. Tier 2 – Complete form on Days 1 & 2 of hospital admission. If transferred to ICU care, please also complete on days 1 & 2 of ICU admission (note these days may be in the past if the patient is enrolled after admission). Additional information can be added to the SUPPLEMENTARY DATA FORM. Enter data to the database at https://www.cliresdms.org

1. DATE OF ASSESSMENT *(DD/MM/YYYY):* [____][____]/[____][____]/[__2_][__0_][____][____] *(may not be the date of completion)*

2. DAILY TREATMENT *(complete every line)*:

Is the patient currently admitted to ICU/ITU/IMC/HDU? ☐YES ☐NO ☐Unknown

Record the most abnormal value in the previous 24 hours *(if Not Available write "NA")*:

FiO_2 *(0.21-1.0)* [___].[___][___] or [___][___]L/min **SaO_2** [___][___][___]%

PaO_2 [___][___][___] ☐kPa *or* ☐mmHg **PaO_2 sample type:** ☐ Arterial ☐ Venous ☐ Capillary ☐Unknown/Not applicable

From same blood gas, record as PaO_2: PCO_2 _____☐kPa *or* ☐mmHg **pH** _____

HCO_3- _____mEq/L **Base excess** _____ mmol/L

Glasgow Coma Score (out of 15) [___][___] **Mean Arterial Blood Pressure** [___][___][___]mmHg

Urine output [___][___][___][___][___]mL/24 hours ☐ Check here if estimated

Is the patient currently receiving, or has s/he received in the past 24 hours *(apply to all 14 questions in this boxed section)* **:**

Mechanical ventilation: Non-invasive (eg. BIPAP, CPAP) ☐YES ☐NO ☐Unknown **Invasive** ☐YES ☐NO ☐Unknown

Oscillatory Ventilation? ☐YES ☐NO ☐Unknown **Extracorporeal membrane oxygenation (ECMO/ECLS)** ☐YES ☐NO ☐Unknown

Interventional lung-assist therapy (iLA)? ☐YES ☐NO ☐Unknown **Dialysis/Hemofiltration?** ☐YES ☐NO ☐Unknown

Any vasopressor/inotropic support? ☐YES ☐NO *(if NO, answer the next 3 questions NO)*

Dopamine <5µg/kg/min OR Dobutamine OR milrinone OR levosimendan: ☐YES ☐NO

Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine: ☐YES ☐NO

Dopamine >15µg/k/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: ☐YES ☐NO

Oral rehydration only? ☐YES ☐NO ☐Unknown **Intravenous Immunoglobulin?** ☐YES ☐NO ☐Unknown

Blood transfusion or products? ☐YES ☐NO ☐Unknown **Plasmapheresis/Exchange?** ☐YES ☐NO ☐Unknown

Other intervention: ☐YES ☐NO ☐Unknown If **YES,** *specify*: _____

3. DAILY LABORATORY RESULTS *Mark the correct unit if a choice is given. If Not Available enter "NA".*

Are results available for samples collected on *the date in section 1 above?* ☐YES *(complete below)* ☐NO *(skip section below)*

Haematology & Biochemistry

Haemoglobin _____ ☐g/L *or* ☐g/dL **Haematocrit** _____ **%** **WBC count** _____ ☐x10^9/L *or* ☐x10^3/µL

Platelets _____ ☐x10^9/L *or* ☐x10^3/µL **☐APTT** _____ **☐PT** _____ seconds *or* **☐INR** _____

ALT/SGPT _____ U/L **Bilirubin** _____☐µmol/L *or* ☐mg/dL **C-reactive protein** _____ ☐mg/L *or* ☐nmol/L

AST/SGOT _____ U/L **Glucose** _____☐mmol/L *or* ☐mg/dL **Erythrocyte Sed Rate** _____ mm/h

Blood Urea Nitrogen (urea) _____ ☐mmol/L *or* ☐mg/d **LDH** _____ U/L

Creatine kinase CPK _____ U/L **Creatinine** _____ ☐µmol/L *or* ☐mg/dL

Lactate _____ ☐mmol/L *or* ☐mg/dL

SUPPLEMENTARY to CORE CASE RECORD FORM - Severe Acute Respiratory Infection

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

EXTRA SPACE FOR INFORMATION ON THE CORE DATA FORM

Use this form to record information that does not fit the space provided in the CASE REPORT FORM or where detailed. All information from the CASE REPORT FORM and this SUPPLEMENTARY DATA FORM should be entered into the appropriate sections of the electronic CASE REPORT FORM at https://www.cliresdms.org

CORE - SECTION 1 - TRAVEL: Did the patient travel in the 14 days prior to first symptom onset? If > 1 *location & date list:*

Country:_____ City/Region: _____ Return Date *(DD/MM/YYYY):* ____ /____ /20_____

Country:_____ City/Region: _____ Return Date *(DD/MM/YYYY):* ____ /____ /20_____

Country:_____ City/Region: _____ Return Date *(DD/MM/YYYY):* ____ /____ /20_____

CORE - SECTION 1 – ANIMAL EXPOSURES: Did the patient have contact with live/dead animals, raw meat or insect bites in the 14 days prior to first symptom onset? *Complete each line below.*
If YES, specify the animal/insect, type of contact and date of exposure (DD/MM/YYYY) here:

Birds (e.g. chickens, turkeys, ducks)	☐YES ☐NO ☐Unknown	
Bats	☐YES ☐NO ☐Unknown	
Livestock (e.g. goats, cattle, camels)	☐YES ☐NO ☐Unknown	
Horses	☐YES ☐NO ☐Unknown	
Hares/ Rabbits	☐YES ☐NO ☐Unknown	
Pigs	☐YES ☐NO ☐Unknown	
Non-human primates	☐YES ☐NO ☐Unknown	
Rodents (e.g. rats, mice, squirrels)	☐YES ☐NO ☐Unknown	
Insect bites (e.g. tick, flea, mosquito)	☐YES ☐NO ☐Unknown	
Reptiles or amphibians	☐YES ☐NO ☐Unknown	
Household pets or other animals living in his/her home (e.g. cats, dogs, other)	☐YES ☐NO ☐Unknown	
Any animal droppings or nests	☐YES ☐NO ☐Unknown	
Any sick or dead animals	☐YES ☐NO ☐Unknown	
Raw animal meat or blood	☐YES ☐NO ☐Unknown	
Skinned, dressed or eaten wild game	☐YES ☐NO ☐Unknown	
Visited live animal market, farm or zoo	☐YES ☐NO ☐Unknown	
Participated in animal surgery or necropsy	☐YES ☐NO ☐Unknown	

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) **[__][__][__] – [__][__][__][__]**

Any other animal contacts:	☐YES ☐NO ☐Unknown	

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER: [__][__][__] - [__][__][__][__]
(3 digit site code – 4 digit sequential patient code)

EXTRA SPACE FOR INFORMATION ON THE CORE DATA FORM - CONTINUED

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CORE - SECTION 2 – ADMISSION IMMUNOSUPPRESSANTS: Receiving immunosuppressants (including inhaled/oral corticosteroids) prior to admission? *Enter the details below.*

Name of immunosuppressant	Dose and frequency	Route of administration	Duration
	☐unknown	☐IV ☐oral ☐inhaled ☐other ☐unknown	☐days ☐weeks ☐unknown
	☐unknown	☐IV ☐oral ☐inhaled ☐other ☐unknown	☐days ☐weeks ☐unknown
	☐unknown	☐IV ☐oral ☐inhaled ☐other ☐unknown	☐days ☐weeks ☐unknown
	☐unknown	☐IV ☐oral ☐inhaled ☐other ☐unknown	☐days ☐weeks ☐unknown
	☐unknown	☐IV ☐oral ☐inhaled ☐other ☐unknown	☐days ☐weeks ☐unknown

CORE - SECTION 2 – ADMISSION ANTI-INFECTIVES: Treated with anti-infectives (antibiotics and anti-virals) for this illness episode prior to admission? *Enter details below.*

Name of medication *(generic name preferred)*	Dose and frequency	Start date *(DD/MM/YYYY)*	End date *(DD/MM/YYYY)*	Route of administration
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown

CORE - SECTION 5 – PATHOGEN TESTING: Was pathogen testing performed during this illness episode? *Add details of testing which did not fit in the CORE CASE REPORT FORM.*

Sample Collection Date *(DD/MM/YYYY)*	**Sample Type** (from list on CORE Section 5)	Method	Result	Pathogen Tested
__ __/__ __/20__ __		☐PCR ☐Culture ☐Other___________	☐Positive ☐Unknown ☐Negative	*Specify:* ______________________
__ __/__ __/20__ __		☐PCR ☐Culture ☐Other___________	☐Positive ☐Unknown ☐Negative	*Specify:* ______________________
__ __/__ __/20__ __		☐PCR ☐Culture ☐Other___________	☐Positive ☐Unknown ☐Negative	*Specify:* ______________________
__ __/__ __/20__ __		☐PCR ☐Culture ☐Other___________	☐Positive ☐Unknown ☐Negative	*Specify:* ______________________
__ __/__ __/20__ __		☐PCR ☐Culture ☐Other___________	☐Positive ☐Unknown ☐Negative	*Specify:* ______________________
__ __/__ __/20__ __		☐PCR ☐Culture ☐Other___________	☐Positive ☐Unknown ☐Negative	*Specify:* ______________________

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

EXTRA SPACE FOR INFORMATION ON THE CORE DATA FORM - CONTINUED

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CORE - SECTION 6 –OTHER INFECTIONS: Did the patient test positive for any other infection? *Add details of testing which did not fit in the CORE CASE REPORT FORM.*			
Sample/Detection Date *(DD/MM/YYYY)*	**Sample Type** *(specify from list on CORE Section 5)*	**Type of Infection**	**Pathogen** *(specify)*
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	
__ __/__ __/20__ __		☐Bacterial ☐Viral ☐Fungal ☐Other:_______________	

CORE – ADDITIONAL INFORMATION: *Detail any additional information not captured in the CASE REPORT FORM.*

____

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SUPPLEMENTARY to CORE CASE RECORD FORM - Severe Acute Respiratory Infection

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

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CORE - SECTION 8 – MEDICATION: ANTI-INFECTIVES & CORTICOSTEROIDS – *List all anti-infectives and corticosteroids administered during hospitalisation and at discharge. Use as many pages as required.*

Name of medication *(generic name preferred)*	**Dose and frequency** *(specify or unknown)*	**Start date** *(DD/MM/YYYY)*	**End date** *(DD/MM/YYYY)*	**Route of administration**
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown
	☐unknown	__ __/__ __/20 __ __	☐On-going __ __/__ __/20 __ __	☐IV ☐oral ☐inhaled ☐other ☐unknown

EPIDEMIOLOGY CASE RECORD FORM - Severe Acute Respiratory Infection

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

ADDITIONAL EPIDEMIOLOGICAL INVESTIGATIONS (Tier 3)

Investigations additional to those on the CASE REPORT FORMs may be of interest to some sites. Some examples of relevant data are below and can be completed at the discretion of the site. All information should be entered into the appropriate sections of the electronic database at https://www.cliresdms.org

EXPOSURES IN THE PREVIOUS 14 DAYS:

Contact (confirmed case): ☐YES ☐NO ☐Unknown **Contact (probable or suspected case):** ☐YES ☐NO ☐Unknown

Travel: ☐YES ☐NO ☐Unknown **Animal:** ☐YES ☐NO ☐Unknown **Occupational:** ☐YES ☐NO ☐Unknown

LIVING SITUATION: What was the primary living situation of the patient in the 14 days before presentation to hospital?

☐Home. # of people at home including patient:_____ ☐Military base ☐Shelter ☐Jail

☐Boarding school/dormitory ☐Nursing home/long-term healthcare facility
☐Other:_____

OCCUPATION: What is the patient's occupation?
_____

VACCINATION HISTORY:

Influenza immunization this season? ☐YES ☐NO ☐Unknown ☐Not applicable as no clear influenza season
If YES: ☐ >14 days prior to illness ☐ <14 days prior to illness
If YES: Immunization type received this season: ☐TIV (injected) ☐LAIV (inhaled)
If YES, <9 years old and first flu vaccination: How many vaccinations were received this season? ☐1 dose ☐2 doses

Pneumococcal vaccination ever? ☐Yes ☐No ☐Unknown
If Yes: Age at receipt of pneumococcal vaccine: _____ years old ☐ Unknown
If YES: Type of vaccine: ☐7-valent conjugate ☐13-valent conjugate ☐23-valent polysaccharide ☐Unknown

Haemophilus influenzae type b vaccination ☐Yes ☐No ☐Unknown
If Yes, age at receipt of haemophilus vaccine: _____ years old ☐ Unknown

RSV immunization Palivizumab (if applicable) ☐Yes ☐No ☐Unknown

World Health Organization ISARIC

PATIENT IDENTIFICATION NUMBER:
(3 digit site code – 4 digit sequential patient code) [__][__][__] - [__][__][__][__]

PHARMACOKINETIC INVESTIGATIONS (Tier 3)

Pharmacokinetic data can be collected on this form. All information should be entered into the appropriate sections of the electronic database at https://www.cliresdms.org

PHARMACOKINETICS (PK) OF ANTIMICROBIALS / IMMUNOMODULATORY DRUGS

Drug under study:	Specify: ________________________
Start date of drug prescription:	Date *(DD/MM/YYYY)* [____][____]/[____][____]/[__2_][__0_][____][____]
Prescribed times of administration:	Specify All: ____
Precise time of 1st PK blood draw today:	Time *(24 hour clock H H : M M)* ___ ___ : ___ ___
Precise time of 2nd PK blood draw today:	Time *(24 hour clock H H : M M)* ___ ___ : ___ ___
Precise time of 3rd PK blood draw today:	Time *(24 hour clock H H : M M)* ___ ___ : ___ ___

Please record all doses of the drug under study given in the last 24hrs:

Dose:	Route of administration	*Precise* Time Drug Given *(if infusion: Start Time)* *(24 hour clock HH:MM)*	*Precise* End Time *(infusion only)* *(24 hour clock HH:MM)*
Amount: ___________ Units:____________	☐IV ☐oral ☐inhaled ☐other:_______________	___ ___ : ___ ___	___ ___ : ___ ___
Amount: ___________ Units:____________	☐IV ☐oral ☐inhaled ☐other:_______________	___ ___ : ___ ___	___ ___ : ___ ___
Amount: ___________ Units:____________	☐IV ☐oral ☐inhaled ☐other:_______________	___ ___ : ___ ___	___ ___ : ___ ___
Amount: ___________ Units:____________	☐IV ☐oral ☐inhaled ☐other:_______________	___ ___ : ___ ___	___ ___ : ___ ___
Amount: ___________ Units:____________	☐IV ☐oral ☐inhaled ☐other:_______________	___ ___ : ___ ___	___ ___ : ___ ___
Amount: ___________ Units:____________	☐IV ☐oral ☐inhaled ☐other:_______________	___ ___ : ___ ___	___ ___ : ___ ___