ISARIC

CASE RECORD FORM for Cases of Human Infection with the Novel Coronavirus – 15/03/2013

Please complete sections 1-4 at admission (or with data available from admission day). Complete sections 5-10 after discharge/death. Additional information can be recorded on the SUPPLEMENTARY DATA FORM.

1. Demographics

This page completed: ☐At admission ☐During hospital stay ☐After discharge

Patient identification code: ___ ___ - ___ ___ ___ **Date of birth** *(DD/MM/YYYY)*: ___ /___ /____ OR **Estimated age** ____

Clinical centre:______________________________**Country:**______________**Form completed by:**__________________

First name initial: ____ **Surname initial:** ____ **Sex:** ☐Male ☐Female **Ethnicity:** ____________ ____________☐Unknown

Weight (at admission): ______kg / lbs *(circle)* **Height**: _______cm / inches *(circle)*

Admission date at this facility *(DD/MM/YYYY)*: ___ /___/20___ **Transferred from another facility?** ☐Yes ☐No ☐Unknown

If YES: **Date admitted** to other facility *(DD/MM/YYYY)*:__ /__/20____ **Name of transferring facility**:_______________________

History of close contact with a human novel coronavirus case? ☐Yes, confirmed case ☐Yes, suspected case ☐No ☐Unknown

Has the patient travelled within 10 days of symptom onset? ☐Yes ☐No ☐Unknown If YES, ***state location(s) below:***

Country:________________________ City: ________________________ Return Date *(DD/MM/YYYY)*: ____ /____ /20______

Country:________________________ City: ________________________ Return Date *(DD/MM/YYYY)*: ____ /____ /20______

In the previous 10 days, did the patient have contact with live animals? ☐Yes ☐No ☐Unknown

If YES, specify **Animal** _____________________ **Type of contact:**____

2. Co-morbidities & Risk Factors *(identified PRIOR TO ADMISSION & that are active problems)* *(Charlson Index will be calculated at analysis)*

Condition	Response	Condition	Response
Congestive heart failure	☐Yes ☐No ☐Unknown	Diabetes with chronic complications	☐Yes ☐No ☐Unknown
Dementia	☐Yes ☐No ☐Unknown	Hemiplegia or paraplegia	☐Yes ☐No ☐Unknown
Chronic pulmonary disease *(not asthma)*	☐Yes ☐No ☐Unknown	Renal disease	☐Yes ☐No ☐Unknown
Chronic pulmonary disease (physician diagnosed asthma)	☐Yes ☐No ☐Unknown	Any malignancy including leukaemia & lymphoma	☐Yes ☐No ☐Unknown
Rheumatologic disease	☐Yes ☐No ☐Unknown	Metastatic solid tumour	☐Yes ☐No ☐Unknown
Mild liver disease	☐Yes ☐No ☐Unknown	AIDS / HIV	☐Yes ☐No ☐Unknown
Moderate or severe liver disease	☐Yes ☐No ☐Unknown	Obese as defined by clinical staff	☐Yes ☐No ☐Unknown

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

Receiving immunosuppressants (including inhaled/oral corticosteroids) prior to admission? ☐Yes ☐No ☐Unknown If YES:

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

Pregnant? ☐Yes ☐No ☐NA ☐Unknown **Gestation at admission:** ________weeks *(round to nearest)*

Post-partum? ☐Yes ☐No ☐NA **Delivery date** *(DD/MM/YYYY)* __ /___/20__ **Outcome:** ☐Live birth ☐Still birth

Baby tested for novel CoV? ☐Yes ☐No ☐Unknown **If YES:** ☐Positive ☐Negative **Method:** ☐PCR ☐Other __________

Infants (<1 year old): birth weight if known: ______kg/lbs *(circle)* ☐ 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 admission *(please complete every line)*

Date of onset of earliest symptom *(DD/MM/YYYY)*:___/___/20___ *OR* ***if unknown, day*-of-illness at admission:**______days

Temperature:_________°C/°F *(circle)* **HR:** _______beats per minute **RR:**________ breaths per minute

Systolic BP:_______mmHg **Diastolic BP:** _______mmHg **Sternal capillary refill time >2secs?** ☐Yes ☐No ☐Unknown

Intubated & ventilated? ☐Yes ☐No ☐Unknown **If intubated & ventilated:** FiO_2 ________ ☐Unknown

Not ventilated but receiving O_2**?** ☐Yes ☐No ☐Unknown O_2 **saturation:** _____% **On room air?** ☐Yes ☐No ☐Unknown

Severe dehydration? ☐Yes ☐No ☐Unknown

Urine output: ☐Oliguria (<1mL/kg/hr infants, <0.5mL/kg/hr children and adults) ☐Anuria (no urine output) ☐ Unknown

Admission signs and symptoms *(associated with this episode of acute illness)*

Symptom	Response	Symptom	Response
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:	____________________

4. Admission Laboratory Results

Please circle the unit used for each parameter, where appropriate. Enter "NM" if not measured.

Biochemistry & Haematology

Date laboratory samples collected (DD/MM/YYYY): ____ /____ /20_____ ☐No results available

Haemoglobin ______ **g/L,** g/dL **Haematocrit** ____________% **WBC count** ____________ **x** 10^9**/L,** $x10^3/\mu L$

Platelets __________ **x** 10^9**/L,** $x10^3/\mu L$ **APTT/INR** *(circle)* _________ **PT** __________________ **seconds**

ALT/SGPT _________ **U/L** **Bilirubin** _______**µmol/L,** mg/dL **C-reactive protein** ________ **mg/L**, nmol/L

AST/SGOT _________ **U/L** **Glucose** _______**mmol/L,** mg/dL **Erythrocyte Sed Rate** ______**mm/h**

Blood Urea Nitrogen _____ **mmol/L,** mg/dL **LDH** __________ **U/L** **Creatine kinase (CPK)** ______**U/L**

Creatinine _________ **µmol/L,** mg/dL **Lactate** _______ **mmol/L,** mg/dL

Blood Gas

Date blood gas performed (DD/MM/YYYY): ____ /____ /20_____ ☐Blood gas not performed

Sample taken on: ☐ Room air ☐Supplemental O_2 ☐Unknown **If receiving** O_2**, specify:** _________**%** **or** ________**l/min**

Sample type: ☐ Arterial ☐ Venous ☐ Capillary ☐Unknown

PO_2___________**kPa**, mmHg **pH**_________________ HCO_3**-** _____________**mEq/L**

PCO_2___________**kPa**, mmHg **Base excess** __________**mmol/L** **Lactate**_____________**mmol/L**, mg/dL

Any other significant laboratory results:____

Patient identification code: ___ ___ - ___ ___ ___ **Date of birth** *(DD/MM/YYYY)*: ___ /___ /____

5. Complications: At any time during hospitalisation did the patient experience *(please 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
Cardiac infection (endo/myo/peri-carditis)	☐Yes ☐No ☐Unknown	Hypoglycemia	☐Yes ☐No ☐Unknown
Cardiac arrhythmia	☐Yes ☐No ☐Unknown	Other	☐Yes ☐No ☐Unknown
		If Other, specify:	____________________

6. Treatment: At any time during hospitalisation, did the patient receive *(please complete every line)*

If Daily Treatment was recorded on a DAILY RECORD FORM (Section 2), leave this section blank and check here ☐

Care on ICU/ITU/IMC/HDU? ☐Yes ☐No ☐Unknown

If YES, state the **Date of admission** to ICU/ITU/IMC/HDU (DD/MM/YYYY): ____ /____ /20____ ☐Date Unknown

If YES, state the **Total number of days** in ICU/ITU/IMC/HDU during this hospital stay: _______days ☐Days Unknown

Supplemental oxygen? ☐Yes ☐No ☐Unknown ………… If YES, duration: _________ days

Non-invasive mechanical ventilation? (eg. BIPAP, CPAP) ☐Yes ☐No ☐Unknown………… If YES, duration: _________ days

Invasive mechanical ventilation? ☐Yes ☐No ☐Unknown………… If YES, duration: _________ days

Oscillatory Ventilation? ☐Yes ☐No ☐Unknown ………… If YES, duration: _________ days

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

☐ECMO ☐iLA ☐None ☐Unknown ………… If YES, duration: ________ days

Renal replacement therapy (RRT) or dialysis? ☐Yes ☐No ☐Unknown………… If YES, duration: _________ days

RRT required beyond discharge from hospital? ☐Yes ☐No ☐Unknown

Plasmapheresis? ☐Yes ☐No ☐Unknown

Inotropes/vasopressors? ☐Yes ☐No ☐Unknown

Oral rehydration only? ☐Yes ☐No ☐Unknown

Intravenous Immunoglobulin? ☐Yes ☐No ☐Unknown

Blood transfusion or products? ☐Yes ☐No ☐Unknown

OTHER intervention *(please specify)*: ____

____

7. Novel Coronavirus Testing

Only record results that are not recorded on a DAILY RECORD FORM (Section 4).

Was testing for novel coronavirus infection performed? ☐Yes ☐No ☐Unknown *If YES, complete each line below.*

Date *(DD/MM/YYYY)*	**Sample Type**	**Result**	**Method**
____ /____ /20____	**Flocked nasal+throat swab**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Nasal/NP swab**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Throat swab**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Sputum**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**BAL**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**ETA**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Stool**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Urine**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Blood**	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Other (specify):** ________________________	☐Positive ☐Negative ☐Not Done	☐PCR ☐other____________
____ /____ /20____	**Serology**	☐Positive ☐Negative ☐Not Done	

8. Other Infections:

Did the patient test positive for any other infection? ☐Yes ☐No ☐Unknown *If YES, specify.*

☐ Bacterial Name of pathogen:______________________________ Date of detection: (DD/MM/YYYY): ____ /____ /20___

☐ Viral Name of pathogen:______________________________ Date of detection: (DD/MM/YYYY): ____ /____ /20___

☐ Fungal Name of pathogen:______________________________ Date of detection: (DD/MM/YYYY): ____ /____ /20___

☐ Other Name of pathogen:______________________________ Date of detection: (DD/MM/YYYY): ____ /____ /20___

9. Medication: While hospitalised or at discharge, were any of the following administered:

Antivirals? ☐Yes ☐No ☐Unknown **Antibiotics?** ☐Yes ☐No ☐Unknown

Corticosteroids? ☐Yes ☐No ☐Unknown **Antifungals?** ☐Yes ☐No ☐Unknown

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

List ONLY ANTI-INFECTIVES and CORTICOSTEROIDS administered in hospital or at discharge.

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

10. Outcome: **Date outcome section completed** *(DD/MM/YYYY)*: ____ /____ /20______

Recovered? ☐Yes ☐No ☐Unknown

If YES, date of recovery *(DD/MM/YYYY)*: ____ /____ /20______ ☐ Date Unknown

Still in hospital? ☐Yes ☐No ☐Unknown

Transferred to another facility? ☐Yes ☐No ☐Unknown

If YES, date of transfer *(DD/MM/YYYY)*: ____ /____ /20______ Name of transfer facility: __________________☐Unknown

Discharged? ☐Yes ☐No ☐Unknown If YES, state the date of discharge *(DD/MM/YYYY)*: ____ /____ /20______

Ability to self-care at discharge versus prior to illness: ☐Same as prior to illness ☐Decreased ☐Increased ☐Unknown

Post-discharge treatment *(if alive, check all that apply)***:**

Respiratory support/treatment ☐Yes ☐No ☐Unknown Renal Treatment ☐Yes ☐No ☐Unknown

Other ☐Yes ☐No ☐Unknown

If YES, specify other treatment *(multiple permitted)*:____

____

Diagnoses at discharge: 1.____

2.____

3.____

4.____

5.____

Died in hospital? ☐Yes ☐No ☐Unknown If YES, date of death *(DD/MM/YYYY)*: ____ /____ /20______

Cause(s) of death: ____

____

____

____

Was an autopsy performed? ☐Yes ☐No ☐Unknown

Key autopsy results:____

____

____

____