ISARIC

SUPPLEMENTARY DATA FORM for Cases of Human Infection with Novel Coronavirus – 15/03/13

Use this form to record information that does not fit the space provided in the CASE REPORT FORM. All information from the CASE REPORT FORM and SUPPLEMENTARY DATA FORM should be entered into the appropriate sections of the electronic CASE REPORT FORM.

1. Case Tracking Information

Demographics should match those entered in the CRF

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

First name initial: ____ **Surname initial:** ____

2. Has the patient travelled within 10 days of symptom onset – Additional Travel Locations

*This refers to **Section 1-Demographics** of the CRF. If more than two locations were visited, enter the details of additional locations below:*

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

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

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

3. In the previous 10 days, did the patient have contact with live animals – Additional Animal Contacts

*This refers to **Section 1-Demographics** of the CRF. If there was more than one animal contact, enter the details of additional contacts below:*

Animal _____ **Type of contact:**_____

Animal _____ **Type of contact:**_____

Animal _____ **Type of contact:**_____

Animal _____ **Type of contact:**_____

4. Receiving immunosuppressants prior to admission – Additional Immunosuppressants

*This refers to **Section 2-Co-morbidities & Risk Factors** of the CRF. If more than one immunosuppressant was being taken by the patient prior to admission, please enter the details of additional immunosuppresants 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

5. Other Infections: Did the patient test positive for any other infection? – Additional infections

*This refers to **Section 8-Other Infections** of the CRF. If the patient was positive for more than one of any type of infection, please enter the details of additional infections below:*

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

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

☐ Viral 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____

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

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

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

6. Anti-infective and corticosteroid medications received during hospitalisation or at discharge – Additional Medications

This refers to ***Section 9-Medication*** of the CRF. If further space is required to list additional anti-infective or corticosteroid medications, please enter them below:

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

7. Any other additional information *Enter any other relevant information not captured in the CRF*

This information can be entered into ***Section 11-Additional Information*** of the electronic CRF on the CliRes database.

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