



ZIKA VIRUS CASE REPORT FORMS – ADULT AND CHILD >5YEARS INTENSIVE CARE – (ACIC)



Patient's Identification Code : _____

Introduction

This standardized Case Report Form (CRF) is the result of an ongoing effort between the World Health Organization (WHO), The Pan-American Health Organization (PAHO), Institute Pasteur (IP), and the networks of ISARIC, CONISE PREPARE and REACTing to generate standardized clinical and epidemiological research tools.

DESIGN OF THIS CASE REPORT FORM (CRF)

There are sets of Case Report Forms (CRFs) to be used in combination for prospective cohort studies or case control studies. These sets of CRFs are to be used at admission and at discharge/going home. For any patients admitted for more than 24 hours, the Baseline and Outcome CRF and the Laboratory Results CRF can be copied and used for daily data recording.

For all studies, we recommend completing a minimum of the **Adult/Child Baseline and Outcome (ACBO)** CRF, followed by **Adult/Child Laboratory Results (ACLR)** CRFs. If the patient is admitted to an Intensive Care Unit or Pediatric Intensive Care Unit, complete **Adult/Child Intensive Care (ACIC)** as well. If the patient is admitted to a hospital or has further investigations, complete **Adult/Child Acute Symptoms (ACAS)**, **Adult/Child Hospital Stay (ACHS)** and **Adult/Child Laboratory Results (ACLR)** for every day of admission.

Complete the outcomes sections in the **ACBO** CRF once all diagnostics laboratory results and final diagnosis are available.

HOW TO USE THIS CRF

When completing the CRF modules, please make sure that:

- The patient or consultee/guardian/representative has been given information about the study and the informed consent form has been completed and signed.
- The study ID codes have been assigned for the patient as per hospital protocol and guidelines.
- The study ID codes have been filled in on all pages of paper CRF forms, all information should be kept confidential at all times, and no identifiable information is recorded on the CRFs.
- Patient's hospital ID and contact details are recorded on a separate contact list to allow later follow up. The contact forms must be kept separate from the CRFs at all times and kept in a secure location.

Each site may choose which data to collect based on available resources and the number of patients enrolled to date. Ideally, data on patients will be collected using all CRF modules as appropriate.

Sites with very low resources or very high patient numbers may select the Adult/Child Baseline and Outcome (ACBO) CRF module only. The decision is up to the site Investigators and may be changed throughout the data collection period. All high quality data are valuable for analysis.

GENERAL GUIDANCE

- The CRFs are designed to collect data obtained through patient examination, for patient or parent/guardian/representative interview and review of hospital notes.
- Patient ID codes should be filled in on all pages of paper CRF forms.
- 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 indicate when the answer to a particular question is not known. Please mark the 'Unknown' box if this is the case.
- Some sections have open areas where you can write additional information. To permit standardized 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 contact us, if we can help with any CRF completion questions, if you have comments, and to let us know that you are using the forms. Please contact Dr Gail Carson by email: gail.carson@ndm.ox.ac.uk



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Disclaimer: These CRFs are intended for use as a standardized document for the collection of clinical data in studies investigating the Zika virus. Responsibility for use of these CRFs rests with the study investigators. ISARIC and the authors of the CRF accept no responsibility for the use of the CRF in an amended format nor for the use of the standardized CRF outside its intended purpose. *Formatting issues are in the process of being resolved. Word documents are available in order to adapt and translate the CRFs, however, there may be issues between Macs and PCs. The PDF format is also available, which should be well formatted on both systems.*

1. Date of admission to intensive care unit (dd/mm/yyyy)	__ / __ / 20__
2. Reason for admission to intensive care	<input type="checkbox"/> Organ failure <input type="checkbox"/> Monitoring <input type="checkbox"/> Other
3. If organ failure specify organs	<input type="radio"/> Cardiovascular <input type="radio"/> Respiratory <input type="radio"/> Renal <input type="radio"/> Hepatic <input type="radio"/> Coagulopathy <input type="radio"/> Unknown <input type="radio"/> Other (specify): _____
4. Date of discharge from intensive care (dd/mm/yyyy)	__ / __ / 20__
5. Discharged to	<input type="checkbox"/> General ward <input type="checkbox"/> Other hospital <input type="checkbox"/> Home <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown
6. If discharged to another hospital Name & Location of hospital:	

1) CRITICAL CARE (record the most abnormal result during admission to high dependency)

Respiratory assessment			
7. Oxygen saturation (SaO₂)	_____ %	<input type="checkbox"/> Room air	<input type="checkbox"/> Supplementary oxygen
8. FIO₂ (0.21-1.0):	_____ or _____	L/min	
9. PaO₂	_____ kPa / mmHg	<input type="checkbox"/> Venous	<input type="checkbox"/> Capillary <input type="checkbox"/> Arterial sample
10. PaCO₂	_____ kPa / mmHg	<input type="checkbox"/> Venous	<input type="checkbox"/> Capillary <input type="checkbox"/> Arterial sample
11. HCO₃	_____ mmol/L	<input type="checkbox"/> Venous	<input type="checkbox"/> Capillary <input type="checkbox"/> Arterial sample
12. Base Excess	_____ mmol/L	<input type="checkbox"/> Venous	<input type="checkbox"/> Capillary <input type="checkbox"/> Arterial sample
13. pH	_____	<input type="checkbox"/> Venous	<input type="checkbox"/> Capillary <input type="checkbox"/> Arterial sample
Respiratory support			
14. High flow O₂	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, start date?</i>	[dd/mm/yyyy] __ / __ / ____
15. Non-invasive ventilation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, start date?</i>	[dd/mm/yyyy] __ / __ / ____
16. Intubation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, intubation date?</i>	[dd/mm/yyyy] __ / __ / ____
17. ECMO	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, start date?</i>	[dd/mm/yyyy] __ / __ / ____
Cardiovascular support			
18. Venous access	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>if yes</i>	<input type="radio"/> Peripheral <input type="radio"/> Central venous <input type="radio"/> Interosseous
19. Vasopressors / inotropes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, start date?</i>	[dd/mm/yyyy] __ / __ / ____
Renal support			
20. Urine output	_____ ml/hr	Patient's Weight	_____ kg
21. Hemofiltration	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, start date?</i>	[dd/mm/yyyy] __ / __ / ____



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2) MEDICATIONS ADMINISTERED (while in intensive care/high dependency)

22. List medications administered from date of admission. Use generic names and include antibiotics, antivirals, corticosteroids, immunoglobulin, anticonvulsants, fluids and others.

Type of medication	Name of medication (generic name)	Dose (for fluids indicate volume)	Frequency (a day)	Start date (dd/mm/yyyy)	Number of days	Route of administration
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
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						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical



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						<input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:
						<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Topical <input type="checkbox"/> Other, specify:

If there is insufficient space please photocopy this page for additional sheets

3) CASE REPORT FORM COMPLETED BY

Name and role			
Signature		Date (dd/mm/yyyy)	