

Global COVID-19 Clinical Platform

NOVEL CORONAVIRUS (COVID-19) - RAPID VERSION

DESIGN OF THIS CASE RECORD FORM (CRF)

This CRF has 3 modules:

Module 1 to be completed on the first day of admission to the health centre.

Module 2 to be completed on first day of admission to ICU or high dependency unit. Module 2 should also be completed daily for as many days as resources allow. Continue to follow-up patients who transfer between wards.

Module 3 to be completed at discharge or death.

GENERAL GUIDANCE

- The CRF is designed to collect data obtained through examination, interview and review of hospital notes. Data may be collected retrospectively if the patient is enrolled after the admission date.
- Participant Identification Numbers consist of a site code and a participant number. You can obtain a site code and register on the data management system by contacting ncov@isaric.org. Participant numbers should be assigned sequentially for each site beginning with 00001. In the case of a single site recruiting participants on different wards, or where it is otherwise difficult to assign sequential numbers, you can assign numbers in blocks or incorporate alpha characters. E.g. Ward X will assign numbers from 00001 or A0001 onwards and Ward Y will assign numbers from 50001 or B0001 onwards. Enter the Participant Identification Number at the top of every page.
- Data are entered to the central electronic REDCap database at <https://ncov.medsci.ox.ac.uk> or to your site/network's independent database. Printed paper CRFs may be used and the data can be typed into the electronic database afterwards.
- Complete every section. Questions marked "If yes,..." should be left blank when they do not apply (i.e. when the answer is not yes).
- Selections with square boxes (☐) are single selection answers (choose one answer only).
- Selections with circular boxes (☐) are multiple selection answers (choose all that apply).
- Mark 'Unknown' for any data that are not available or unknown.
- Avoid recording data outside of the dedicated areas.
- If using paper CRFs, we recommend writing clearly in ink, using BLOCK-CAPITAL LETTERS.
- Place an (X) in the boxes to mark the 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 participant together e.g. with a staple or participant-unique folder.
- Please transfer all paper CRF data to the electronic database. All paper CRFs can be stored by the institution responsible for them. All data should be transferred to the secure electronic database.
- Please enter data on the electronic data capture system at <https://ncov.medsci.ox.ac.uk>. If your site would like to collect data independently, we can support the establishment of locally hosted databases.
- Please contact us at ncov@isaric.org. If we can help with databases, if you have comments and to let us know that you are using the forms.

MODULE1: complete on admission/enrolment

Site name |

Country |

Date of enrolment | | | | | | | | | | | | | | | | | |

CLINICAL INCLUSION CRITERIA			
Proven or suspected infection with pathogen of Public Health Interest <input type="checkbox"/> Yes <input type="checkbox"/> No			
One or more		A history of self-reported feverishness or measured fever of $\geq 38.0^{\circ}\text{C}$	<input type="checkbox"/> Yes <input type="checkbox"/> No
of these		Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
during this		Dyspnoea (shortness of breath) OR Tachypnoea*	<input type="checkbox"/> Yes <input type="checkbox"/> No
illness		Clinical suspicion of ARI despite not meeting criteria above	<input type="checkbox"/> Yes <input type="checkbox"/> No
* respiratory rate ≥ 50 breaths/min for <1 year; ≥ 40 for 1-4 years; ≥ 30 for 5-12 years; ≥ 20 for ≥ 13 years			

DEMOGRAPHICS	
Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not specified	Date of birth
If date of birth is unknown, record: Age years OR months	
Healthcare Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Laboratory Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A	If yes: Gestational weeks assessment weeks

DATE OF ONSET AND ADMISSION VITAL SIGNS (first available data at presentation/admission)	
Symptom onset (date of first/earliest symptom)	
Admission date at this facility	
Temperature . $^{\circ}\text{C}$	Heart rate beats/min
Respiratory rate breaths/min	
BP (systolic) (diastolic) mmHg	Severe dehydration <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Sternal capillary refill time >2 seconds <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Oxygen saturation: % on <input type="checkbox"/> room air <input type="checkbox"/> oxygen therapy <input type="checkbox"/> Unknown	A V P U (circle one)
Glasgow Coma Score (GCS /15)	Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Mid-upper arm circumference mm	Height: cm Weight: kg

CO-MORBIDITIES (existing prior to admission) (Unk = Unknown)			
Chronic cardiac disease (not hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic pulmonary disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Asplenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Malignant neoplasm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chronic neurological disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If yes, specify:	
HIV	<input type="checkbox"/> Yes-on ART <input type="checkbox"/> Yes-not on ART <input type="checkbox"/> No <input type="checkbox"/> Unknown		

PRE-ADMISSION & CHRONIC MEDICATION	
Were any of the following taken within 14 days of admission?	
Angiotensin converting enzyme inhibitors (ACE inhibitors)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Angiotensin II receptor blockers (ARBs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Non-steroidal anti-inflammatory (NSAID)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

SIGNS AND SYMPTOMS ON ADMISSION (Unk = Unknown)					
History of fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lower chest wall indrawing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Headache.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
with sputum production	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Altered consciousness/confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
with haemoptysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Sore throat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Runny nose (rhinorrhoea).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Vomiting / Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhoea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Chest pain.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Muscle aches (myalgia)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Joint pain (arthralgia).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Skin ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Fatigue / Malaise	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Lymphadenopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Shortness of breath .	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Bleeding (Haemorrhage).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
Inability to walk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If bleeding: specify site(s):			
Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, specify: _____					
MEDICATION Is the patient CURRENTLY receiving any of the following?					
Oral/orogastric fluids? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Intravenous fluids? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Antiviral? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes: <input type="radio"/> Ribavirin <input type="radio"/> Lopinavir/Ritonavir <input type="radio"/> Neuraminidase inhibitor					
<input type="radio"/> Interferon alpha <input type="radio"/> Interferon beta <input type="radio"/> Other, specify: _____					
Corticosteroid? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, route: <input type="radio"/> Oral <input type="radio"/> Intravenous <input type="radio"/> Inhaled					
If yes, please provide agent and maximum daily dose: _____					
Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Antifungal agent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Antimalarial agent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify: _____					
Experimental agent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, specify: _____					
Non-steroidal anti-inflammatory (NSAID) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Angiotensin converting enzyme inhibitors (ACE inhibitors) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Angiotensin II receptor blockers (ARBs) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
SUPPORTIVE CARE Is the patient CURRENTLY receiving any of the following?					
ICU or High Dependency Unit admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Oxygen therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, complete all below					
O ₂ flow: <input type="checkbox"/> 1-5 L/min <input type="checkbox"/> 6-10 L/min <input type="checkbox"/> 11-15 L/min <input type="checkbox"/> >15 L/min <input type="checkbox"/> Unknown					
Source of oxygen: <input type="checkbox"/> Piped <input type="checkbox"/> Cylinder <input type="checkbox"/> Concentrator <input type="checkbox"/> Unknown					
Interface: <input type="checkbox"/> Nasal prongs <input type="checkbox"/> HF nasal cannula <input type="checkbox"/> Mask <input type="checkbox"/> Mask with reservoir <input type="checkbox"/> CPAP/NIV mask <input type="checkbox"/> Unknown					
Non-invasive ventilation? (e.g.BIPAP/CPAP) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A					
Invasive ventilation (Any)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Inotropes/vasopressors? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Extracorporeal (ECMO) support? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Prone position? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
LABORATORY RESULTS ON ADMISSION (*record units if different from those listed)					
Parameter	Value*	Not done	Parameter	Value*	Not done
Haemoglobin (g/L)		<input type="checkbox"/>	Creatinine (μmol/L)		<input type="checkbox"/>
WBC count (x10 ⁹ /L)		<input type="checkbox"/>	Sodium (mEq/L)		<input type="checkbox"/>
Haematocrit (%)		<input type="checkbox"/>	Potassium (mEq/L)		<input type="checkbox"/>
Platelets (x10 ⁹ /L)		<input type="checkbox"/>	Procalcitonin (ng/mL)		<input type="checkbox"/>
APTT/APTR		<input type="checkbox"/>	CRP (mg/L)		<input type="checkbox"/>
PT (seconds)		<input type="checkbox"/>	LDH (U/L)		<input type="checkbox"/>
INR		<input type="checkbox"/>	Creatine kinase (U/L)		<input type="checkbox"/>
ALT/SGPT (U/L)		<input type="checkbox"/>	Troponin (ng/mL)		<input type="checkbox"/>
Total bilirubin (μmol/L)		<input type="checkbox"/>	ESR (mm/hr)		<input type="checkbox"/>
AST/SGOT (U/L)		<input type="checkbox"/>	D-dimer (mg/L)		<input type="checkbox"/>
Urea (BUN) (mmol/L)		<input type="checkbox"/>	Ferritin (ng/mL)		<input type="checkbox"/>
Lactate (mmol/L)		<input type="checkbox"/>	IL-6 (pg/mL)		<input type="checkbox"/>

MODULE 2: follow-up (frequency of completion determined by available resources)

Date of follow up [_D_] [_D_] / [_M_] [_M_] / 2 [_0_] [_Y_] [_Y_]

VITAL SIGNS (record most abnormal value between 00:00 to 24:00)

Temperature [°C]	Heart rate [beats per min]	Respiratory rate [breaths/min]
36.5	72	16
36.8	75	18
37.1	78	20
37.4	81	22
37.7	84	24
38.0	87	26
38.3	90	28
38.6	93	30
38.9	96	32
39.2	99	34
39.5	102	36
39.8	105	38
40.1	108	40
40.4	111	42
40.7	114	44
41.0	117	46
41.3	120	48
41.6	123	50
41.9	126	52
42.2	129	54
42.5	132	56
42.8	135	58
43.1	138	60
43.4	141	62
43.7	144	64
44.0	147	66
44.3	150	68
44.6	153	70
44.9	156	72
45.2	159	74
45.5	162	76
45.8	165	78
46.1	168	80
46.4	171	82
46.7	174	84
47.0	177	86
47.3	180	88
47.6	183	90
47.9	186	92
48.2	189	94
48.5	192	96
48.8	195	98
49.1	198	100
49.4	201	102
49.7	204	104
50.0	207	106
50.3	210	108
50.6	213	110
50.9	216	112
51.2	219	114
51.5	222	116
51.8	225	118
52.1	228	120
52.4	231	122
52.7	234	124
53.0	237	126
53.3	240	128
53.6	243	130
53.9	246	132
54.2	249	134
54.5	252	136
54.8	255	138
55.1	258	140
55.4	261	142
55.7	264	144
56.0	267	146
56.3	270	148
56.6	273	150
56.9	276	152
57.2	279	154
57.5	282	156
57.8	285	158
58.1	288	160
58.4	291	162
58.7	294	164
59.0	297	166
59.3	300	168
59.6	303	170
59.9	306	172
60.2	309	174
60.5	312	176
60.8	315	178
61.1	318	180
61.4	321	182
61.7	324	184
62.0	327	186
62.3	330	188
62.6	333	190
62.9	336	192
63.2	339	194
63.5	342	196
63.8	345	198
64.1	348	200
64.4	351	202
64.7	354	204
65.0	357	206
65.3	360	208
65.6	363	210
65.9	366	212
66.2	369	214
66.5	372	216
66.8	375	218
67.1	378	220
67.4	381	222
67.7	384	224
68.0	387	226
68.3	390	228
68.6	393	230
68.9	396	232
69.2	399	234
69.5	402	236
69.8	405	238
70.1	408	240
70.4	411	242
70.7	414	244
71.0	417	246
71.3	420	24

BP [][](systolic) [][](diastolic) mmHg **Severe dehydration** ☐Yes ☐No ☐Unknown

Sternal capillary refill time >2seconds ☐Yes ☐No ☐Unknown **GCS/15** [][]

Oxygen saturation [] [] % on ☐ room air ☐ oxygen therapy ☐ Unknown **A V P U** (circle one)

DAILY CLINICAL FEATURES (*Unk* = *Unknown*)

Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
and sputum production	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Vomiting / Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Diarrhoea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Conjunctivitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Myalgia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk
Confusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk	Other, specify:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unk

LABORATORY RESULTS (*record units if different from those listed)

Parameter	Value*	Not done	Parameter	Value*	Not done
Haemoglobin (g/L)		<input type="checkbox"/>	Creatinine (μmol/L)		<input type="checkbox"/>
WBC count (x10 ⁹ /L)		<input type="checkbox"/>	Sodium (mEq/L)		<input type="checkbox"/>
Haematocrit (%)		<input type="checkbox"/>	Potassium (mEq/L)		<input type="checkbox"/>
Platelets (x10 ⁹ /L)		<input type="checkbox"/>	Procalcitonin (ng/mL)		<input type="checkbox"/>
APTT/APTR		<input type="checkbox"/>	CRP (mg/L)		<input type="checkbox"/>
PT (seconds)		<input type="checkbox"/>	LDH (U/L)		<input type="checkbox"/>
INR		<input type="checkbox"/>	Creatine kinase (U/L)		<input type="checkbox"/>
ALT/SGPT (U/L)		<input type="checkbox"/>	Troponin (ng/mL)		<input type="checkbox"/>
Total bilirubin (μmol/L)		<input type="checkbox"/>	ESR (mm/hr)		<input type="checkbox"/>
AST/SGOT (U/L)		<input type="checkbox"/>	D-dimer (mg/L)		<input type="checkbox"/>
Urea (BUN) (mmol/L)		<input type="checkbox"/>	Ferritin (ng/mL)		<input type="checkbox"/>
Lactate (mmol/L)		<input type="checkbox"/>	IL-6 (pg/mL)		<input type="checkbox"/>

MEDICATION		Is the patient CURRENTLY receiving any of the following?	
1	Aspirin		
2	Warfarin		
3	Other blood thinners		
4	Insulin		
5	Diabetes pills		
6	ACE inhibitors		
7	Beta blockers		
8	Calcium channel blockers		
9	Diuretics		
10	Statins		
11	Antidepressants		
12	Antipsychotics		
13	Anticonvulsants		
14	Antibiotics		
15	Other medications		

Oral/orogastric fluids? ☐Yes ☐No ☐Unknown **Intravenous fluids?** ☐Yes ☐No ☐Unknown

Antiviral? ☐Yes ☐No ☐Unknown **If yes:** ☐Ribavirin ☐Lopinavir/Ritonavir ☐Neuraminidase inhibitor

☐ Interferon alpha ☐ Interferon beta ☐ Other, specify: _____

Corticosteroid? ☐Yes ☐No ☐Unknown **If yes, route:** ☐Oral ☐Intravenous ☐Inhaled

If **yes**, please provide agent and maximum daily dose: _____

Antibiotic? ☐Yes ☐No ☐Unknown

Antifungal agent? ☐Yes ☐No ☐Unknown

Antimalarial agent? ☐Yes ☐No ☐Unknown **If yes, specify:**

Experimental agent? ☐Yes ☐No ☐Unknown **If yes, specify:** _____

Non-steroidal anti-inflammatory (NSAID) ☐Yes ☐No ☐Unknown

Angiotensin converting enzyme inhibitors (ACE inhibitors) ☐Yes ☐No ☐Unknown

Angiotensin II receptor blockers (ARBs) ☐Yes ☐No ☐Unknown

SUPPORTIVE CARE	Is the patient CURRENTLY receiving any of the following?
<p>1. Pain Management</p> <p>What is the patient's current pain level (0-10)? _____</p> <p>What is the patient's current pain management plan? _____</p>	<p>1. Pain Management</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Oral analgesics</p> <p><input type="checkbox"/> Intravenous analgesics</p> <p><input type="checkbox"/> Intrathecal analgesics</p> <p><input type="checkbox"/> Epidural analgesics</p> <p><input type="checkbox"/> Regional analgesics</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>2. Nausea and Vomiting</p> <p>What is the patient's current nausea and vomiting level (0-10)? _____</p> <p>What is the patient's current nausea and vomiting management plan? _____</p>	<p>2. Nausea and Vomiting</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Antiemetics</p> <p><input type="checkbox"/> Prokinetics</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>3. Constipation</p> <p>What is the patient's current constipation level (0-10)? _____</p> <p>What is the patient's current constipation management plan? _____</p>	<p>3. Constipation</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Laxatives</p> <p><input type="checkbox"/> Stool softeners</p> <p><input type="checkbox"/> Enemas</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>4. Delirium</p> <p>What is the patient's current delirium level (0-10)? _____</p> <p>What is the patient's current delirium management plan? _____</p>	<p>4. Delirium</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Antipsychotics</p> <p><input type="checkbox"/> Sedatives</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>5. Anemia</p> <p>What is the patient's current anemia level (0-10)? _____</p> <p>What is the patient's current anemia management plan? _____</p>	<p>5. Anemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Iron supplements</p> <p><input type="checkbox"/> Erythropoietin</p> <p><input type="checkbox"/> Blood transfusion</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>6. Hypertension</p> <p>What is the patient's current hypertension level (0-10)? _____</p> <p>What is the patient's current hypertension management plan? _____</p>	<p>6. Hypertension</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Antihypertensives</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>7. Hypotension</p> <p>What is the patient's current hypotension level (0-10)? _____</p> <p>What is the patient's current hypotension management plan? _____</p>	<p>7. Hypotension</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Vasopressors</p> <p><input type="checkbox"/> Fluid resuscitation</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>8. Hypoxemia</p> <p>What is the patient's current hypoxemia level (0-10)? _____</p> <p>What is the patient's current hypoxemia management plan? _____</p>	<p>8. Hypoxemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Oxygen therapy</p> <p><input type="checkbox"/> Mechanical ventilation</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>9. Hyperkalemia</p> <p>What is the patient's current hyperkalemia level (0-10)? _____</p> <p>What is the patient's current hyperkalemia management plan? _____</p>	<p>9. Hyperkalemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Potassium binders</p> <p><input type="checkbox"/> Diuretics</p> <p><input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>10. Hypokalemia</p> <p>What is the patient's current hypokalemia level (0-10)? _____</p> <p>What is the patient's current hypokalemia management plan? _____</p>	<p>10. Hypokalemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Potassium supplements</p> <p><input type="checkbox"/> Diuretics</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>11. Hyponatremia</p> <p>What is the patient's current hyponatremia level (0-10)? _____</p> <p>What is the patient's current hyponatremia management plan? _____</p>	<p>11. Hyponatremia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Sodium supplements</p> <p><input type="checkbox"/> Fluid restriction</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>12. Hypernatremia</p> <p>What is the patient's current hypernatremia level (0-10)? _____</p> <p>What is the patient's current hypernatremia management plan? _____</p>	<p>12. Hypernatremia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Water restriction</p> <p><input type="checkbox"/> Hypotonic fluids</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>13. Hypocalcemia</p> <p>What is the patient's current hypocalcemia level (0-10)? _____</p> <p>What is the patient's current hypocalcemia management plan? _____</p>	<p>13. Hypocalcemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Calcium supplements</p> <p><input type="checkbox"/> Vitamin D</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>14. Hypercalcemia</p> <p>What is the patient's current hypercalcemia level (0-10)? _____</p> <p>What is the patient's current hypercalcemia management plan? _____</p>	<p>14. Hypercalcemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Bisphosphonates</p> <p><input type="checkbox"/> Calcitonin</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>15. Hypomagnesemia</p> <p>What is the patient's current hypomagnesemia level (0-10)? _____</p> <p>What is the patient's current hypomagnesemia management plan? _____</p>	<p>15. Hypomagnesemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Magnesium supplements</p> <p><input type="checkbox"/> Diuretics</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>16. Hypermagnesemia</p> <p>What is the patient's current hypermagnesemia level (0-10)? _____</p> <p>What is the patient's current hypermagnesemia management plan? _____</p>	<p>16. Hypermagnesemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Magnesium supplements</p> <p><input type="checkbox"/> Diuretics</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>17. Hypophosphatemia</p> <p>What is the patient's current hypophosphatemia level (0-10)? _____</p> <p>What is the patient's current hypophosphatemia management plan? _____</p>	<p>17. Hypophosphatemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Phosphate supplements</p> <p><input type="checkbox"/> Diuretics</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>18. Hyperphosphatemia</p> <p>What is the patient's current hyperphosphatemia level (0-10)? _____</p> <p>What is the patient's current hyperphosphatemia management plan? _____</p>	<p>18. Hyperphosphatemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Phosphate binders</p> <p><input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>19. Hypoglycemia</p> <p>What is the patient's current hypoglycemia level (0-10)? _____</p> <p>What is the patient's current hypoglycemia management plan? _____</p>	<p>19. Hypoglycemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Insulin</p> <p><input type="checkbox"/> Glucose supplements</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>
<p>20. Hyperglycemia</p> <p>What is the patient's current hyperglycemia level (0-10)? _____</p> <p>What is the patient's current hyperglycemia management plan? _____</p>	<p>20. Hyperglycemia</p> <p>Is the patient currently receiving any of the following?</p> <p><input type="checkbox"/> Insulin</p> <p><input type="checkbox"/> Oral hypoglycemics</p> <p><input type="checkbox"/> Non-pharmacologic measures</p>

ICU or High Dependency Unit admission? ☐Yes ☐No ☐Unknown

Oxygen therapy? ☐Yes ☐No ☐Unknown **If yes, complete all below:**

O₂ flow volume: ☐1-5 L/min ☐6-10 L/min ☐11-15 L/min ☐ >15 L/min ☐Unknown

Source of oxygen: ☐Piped ☐Cylinder ☐Concentrator ☐Unknown

Interface: ☐ Nasal prongs ☐ HF nasal cannula ☐ Mask ☐ Mask with reservoir ☐ CPAP/NIV mask ☐ Unknown

Non-invasive ventilation? (e.g. BIPAP, CPAP) ☐Yes ☐No ☐Unknown

Invasive ventilation (Any)? ☐Yes ☐No ☐Unknown

Inotropes/vasopressors? ☐Yes ☐No ☐Unknown

Extracorporeal (ECMO) support? ☐Yes ☐No ☐Unknown

Prone position? ☐ Yes ☐ No ☐ UnknownRenal replacement therapy (RRT) or dialysis? ☐Yes ☐No ☐Unknown

MODULE 3: complete at discharge/death

DIAGNOSTIC/PATHOGEN TESTING

Chest X-Ray /CT performed? ☐Yes ☐No ☐Unknown **If Yes: infiltrates present?** ☐Yes ☐No ☐Unknown

Was pathogen testing done during this illness episode? ☐Yes ☐No ☐Unknown **If yes, complete all below:**

Influenza virus: ☐Positive ☐Negative ☐Not done **If positive, type** _____

Coronavirus: ☐Positive ☐Negative ☐Not done **If positive:** ☐MERS-CoV ☐SARS-CoV-2 ☐Other _____

Other respiratory pathogen: ☐Positive ☐Negative ☐Not done **If positive, specify** _____

Viral haemorrhagic fever: ☐Positive ☐Negative ☐Not done **If positive, specify virus** _____

Other pathogen of public health interest detected: If yes, specify: _____

Falciparum malaria: ☐Positive ☐Negative ☐Not done **Non-falciparum malaria:** ☐Positive ☐Negative ☐Not done

HIV: ☐Positive ☐Negative ☐Not done

COMPLICATIONS: At any time during hospitalisation did the patient experience:

Shock	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bacteraemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Meningitis/Encephalitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Anaemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Mycarditis/Pericarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiac arrhythmia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Acute renal injury	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Cardiac arrest	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Liver dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Bronchiolitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cardiomyopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Acute Respiratory Distress Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other If Yes, specify	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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

Oral/orogastric fluids? ☐Yes ☐No ☐Unknown **Intravenous fluids?** ☐Yes ☐No ☐Unknown
Antiviral? ☐Yes ☐No ☐Unknown **If yes:** ☐Ribavirin ☐Lopinavir/Ritonavir ☐Neuraminidase inhibitor
☐Interferon alpha ☐Interferon beta ☐Other, specify: _____
Antibiotic? ☐Yes ☐No ☐Unknown **If yes, specify:** _____
Corticosteroid? ☐Yes ☐No ☐Unknown **If yes, route:** ☐Oral ☐Intravenous ☐Inhaled
If yes, specify agent and maximum daily dose: _____
Antifungal agent? ☐Yes ☐No ☐Unknown **If yes, specify:** _____
Antimalarial agent? ☐Yes ☐No ☐Unknown **If yes, specify:** _____
Experimental agent? ☐Yes ☐No ☐Unknown **If yes, specify:** _____
Non-steroidal anti-inflammatory (NSAID) ☐Yes ☐No ☐Unknown **If yes, specify:** _____

SUPPORTIVE CARE: At ANY time during hospitalisation, did the patient receive/undergo:

ICU or High Dependency Unit admission? ☐Yes ☐No ☐Unknown **If yes**, total duration: _____days
Date of ICU admission:[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐N/A
Date of ICU discharge:[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐in ICU at outcome ☐N/A

Oxygen therapy? ☐Yes ☐No ☐Unknown **If yes, complete all:** **Total duration:** _____days
O₂ flow volume: ☒1-5 L/min ☒6-10 L/min ☒11-15 L/min ☒ >15 L/min
Source of oxygen: ☒Piped ☒Cylinder ☒Concentrator
Interface: ☒Nasal prongs ☒HF nasal cannula ☒Mask ☒Mask with reservoir ☒CPAP/NIV mask

Non-invasive ventilation? (e.g. BIPAP, CPAP) ☐Yes ☐No ☐Unknown **If yes**, total duration: _____days

Invasive ventilation (Any)? ☐Yes ☐No ☐Unknown **If yes**, total duration: _____days

Extracorporeal (ECMO) support? ☐Yes ☐No ☐Unknown **If yes**, total duration: _____days

Prone position? ☐Yes ☐No ☐Unknown **If yes**, total duration: _____days

Renal replacement therapy (RRT) or dialysis? ☐Yes ☐No ☐Unknown

Inotropes/vasopressors? ☐Yes ☐No ☐Unknown **If yes**, total duration: _____days

OUTCOME

Outcome: ☐ Discharged alive ☐ Hospitalized ☐ Transfer to other facility ☐ Death ☐ Palliative discharge ☐ Unknown
Outcome date: [D]/[D]/[M][M]/[2][0][Y][Y] ☐ Unknown
If Discharged alive: Ability to self-care at discharge versus before illness: ☐ Same as before illness ☐ Worse
☐ Better ☐ Unknown

COVID-19 CASE REPORT FORM RAPID CRITICAL CARE MODULE

This is an optional form to be completed together with the **RAPID CRF** for patients receiving critical care on whom the data below are available.

RAPID COVID-19 CRF users:

- Complete this form for patients receiving critical care in any ward, in addition to the RAPID COVID-19 CRF.
- Sites should select whether they complete **Part A only** or both **Parts A & B** depending on the availability of data and resources.
- The selected parts of this form (A only or A&B) should be completed in addition to the **RAPID Module 2 (Daily Form) both:**
 - 1) **on the day of admission to an intensive care / high dependency unit or on the first day of deterioration to severe disease in any ward**
 - AND**
 - 2) **each day that the patient is receiving critical care (depending on resource availability).**
- Complete the RAPID CRF as per the RAPID CRF guidance.
- Please note, as indicated on the form, that the top section of Part B is to be completed only once (on the first day of admission to ICU or deterioration to severe disease).

PART A

ADMISSION AND DAILY IN ICU/HDU	
DATE OF ASSESSMENT (DD/MM/YYYY): 	
Current admission to ICU or other High Dependency Unit (HDU)? <input type="checkbox"/> YES –ICU <input type="checkbox"/> Yes -HDU <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
Is the patient currently receiving, or has received (between 00:00 to 24:00 on day of assessment)	
Any vasopressor/inotropic support? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
If YES, what was the highest level of support received on the date of assessment?	
<input type="checkbox"/> Dopamine <5µg/kg/min OR Dobutamine OR milrinone OR levosimendan	
<input type="checkbox"/> Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine	
<input type="checkbox"/> Dopamine >15µg/kg/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min	
<input type="checkbox"/> Unknown	
Prone positioning? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
Neuromuscular blocking agents? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown Inhaled Nitric Oxide? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
Tracheostomy inserted? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown Dialysis/Hemofiltration? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
Other intervention or procedure not already recorded in this form or in the RAPID Module 2 form:	
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES, specify: _____	
Record the values associated with the ‘worst’ blood gas analysis on the day of assessment. ‘Worst’ is defined as the blood gas with the lowest PaO ₂ /FiO ₂ ratio.	
Any supplemental oxygen (record the highest level of support on day of assessment):	
FiO ₂ (0.21-1.0) or % or L/min	
PaO ₂ (at time nearest to the FiO ₂ above) kPa or mmHg <input type="checkbox"/> Not done	
PaO ₂ sample type: <input type="checkbox"/> Arterial <input type="checkbox"/> Capillary <input type="checkbox"/> Unknown	
From same blood gas record as PaO ₂ :	
PCO ₂ kPa or mmHg pH HCO ₃ ⁻ mEq/L Base excess mmol/L	
Richmond Agitation-Sedation Scale (RASS) or Riker Sedation-Agitation Scale (SAS) <input type="checkbox"/> Unknown	
Most abnormal mean arterial blood pressure mmHg <input type="checkbox"/> Unknown	
Urine flow rate IF patient age >18 years mL/24 hours <input type="checkbox"/> Check if estimated <input type="checkbox"/> Unknown	
IF patient age <18 years mL/kg/24hrs <input type="checkbox"/> Check if estimated <input type="checkbox"/> Unknown	

PART B

ICU/HDU ADMISSION FORM (complete on first day of ICU/HDU admission only)	
ICU ADMISSION DATE (DD/MM/YYYY): [D_]/[D_]/[M_][M_]/[2_][0_][Y_][Y_]	
Enrolment in interventional clinical study? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES, name of study: _____ or Treatment/s trialled: _____ _____ <input type="checkbox"/> Unknown	
Reason for ICU admission (tick all that apply): <input type="radio"/> Respiratory failure <input type="radio"/> Septic shock <input type="radio"/> Venous thromboembolism <input type="radio"/> Cardiovascular complications <input type="radio"/> Acute kidney injury <input type="radio"/> Acute liver injury <input type="radio"/> Neurological complications <input type="radio"/> Secondary infection <input type="radio"/> Pancreatic injury <input type="radio"/> Disseminated intravascular coagulation <input type="radio"/> Pregnancy related complications <input type="radio"/> Rhabdomyolysis <input type="radio"/> OTHER (please specify) _____ <input type="checkbox"/> Unknown	
Clinical Frailty Score (CFS/9) [_____] <input type="checkbox"/> Unknown Acute renal failure? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
DAILY FORM (Complete daily for duration of ICU/ITU/IMC/HDU admission) (between 00:00 to 24:00 on day of assessment) Record the 'worst' value on the day of assessment.	
If patient is <18 years: PELOD Total Score [_____] <input type="checkbox"/> Unknown PRISM III score: [_____] <input type="checkbox"/> Unknown	
Fluid balance (in last 24 hours) (mL) _____ <input type="checkbox"/> Unknown	
Nutrition <input type="checkbox"/> Parenteral <input type="checkbox"/> Enteral <input type="checkbox"/> NPO <input type="checkbox"/> Unknown Best physical mobility [____]/10 (see scoring below) <input type="checkbox"/> Unknown	
0 Passively moved by staff (incl. passive cycling only) 1 Any activity in bed, but not moving out of or over edge of bed (incl. cycling) 2 Passively moved to chair (no standing or sitting at edge of bed) 3 Actively sitting over side of bed with some trunk control (may be assisted) 4 Standing 5 Transferring from bed to chair	6 Marching on the spot (at bedside; > 2steps/foot) 7 Walking with assistance of 2 or more people (>5m) 8 Walking with assistance of 1 person (>5m) 9 Walking independently with gait aid (>5m) 10 Walking independently without gait aid (>5m)
Is the patient currently receiving (between 00:00 to 24:00 on day of assessment):	
Invasive ventilation? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES: <input type="radio"/> ETT <input type="radio"/> Tracheostomy <input type="radio"/> OTHER (please specify) _____ <input type="checkbox"/> Unknown	
Non-invasive ventilation? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES: <input type="radio"/> BIPAP <input type="radio"/> CPAP <input type="radio"/> OTHER (please specify) _____ <input type="checkbox"/> Unknown	
Humidified high flow nasal cannula (HHFNC)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	
If mechanically ventilated: Mode of ventilation (specify): <input type="checkbox"/> Volume Controlled (VC) <input type="checkbox"/> Pressure Controlled (PC) _____ <input type="checkbox"/> Other(drop down): _____ <input type="checkbox"/> Unknown	
Highest Tidal volume within last 24hrs (ml/Kg of Ideal Body Weight): _____ <input type="checkbox"/> Unknown	
Highest Positive end expiratory pressure within last 24hrs (cmH2O): _____ <input type="checkbox"/> Unknown	
Highest Airway plateau pressure within last 24 hrs (cmH2O): _____ <input type="checkbox"/> Unknown	
Prone positioning? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, total duration _____ hours spent <input type="checkbox"/> Unknown	
Sedation? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES: <input type="radio"/> Benzodiazepines <input type="radio"/> Propofol <input type="radio"/> Narcotics _____ <input type="radio"/> Other (please specify) _____ <input type="checkbox"/> Unknown	
Diuretic? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES, total duration _____ hours <input type="checkbox"/> Unknown Total daily dose (mg) _____ <input type="checkbox"/> Unknown	
Dialysis/Hemofiltration? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES, <input type="radio"/> CRRT <input type="radio"/> IHD <input type="radio"/> SLED <input type="radio"/> OTHER (please specify) _____ <input type="checkbox"/> Unknown Unknown If CRRT, type of anti-coagulant, <input type="radio"/> Heparin <input type="radio"/> Citrate <input type="checkbox"/> None <input type="checkbox"/> Unknown	
Heparin for systemic anticoagulation ? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES, <input type="radio"/> Low-molecular weight <input type="radio"/> Unfractionated <input type="checkbox"/> Unknown _____ If YES, <input type="radio"/> Subcutaneous <input type="radio"/> Intravenous (IV) <input type="checkbox"/> Unknown _____ If YES, <input type="radio"/> Therapeutic <input type="radio"/> Prophylactic <input type="checkbox"/> Unknown	
Convalescent plasma? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown If YES, transfusion volume (mL) _____ <input type="checkbox"/> Unknown	
Blood transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown Platelet transfusion? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Unknown	