**PATIENTNT IDENTIFICATION #: [___][___][___]-- [___][___][___][___]**

# COVID-19 CASE REPORT FORM

**This Case Report Form (CRF) has been adapted from the ISARIC/WHO COVID-19 Case Report Form.** Available from https://media.tghn.org/medialibrary/2020/05/ISARIC_WHO_nCoV_CORE_CRF_23APR20.pdf

The CRF collects basic sociodemographic and clinical data from suspected and confirmed cases of COVID-19. Refer to the data management document for further information.

**GENERAL GUIDANCE:**

- The CRF is designed to collect data obtained through interview, examination, review of patients and hospital notes. Data may be collected retrospectively.
- Participant Identification Numbers consist of a 3-digit site code and a 4-digit participant number.
- Data should be entered to the prepared electronic REDCap database (preferred). Although not intended presently, printed paper CRFs may be used for later transfer of the data onto the electronic database. If using paper CRFs, we recommend writing clearly in ink, using BLOCK-CAPITAL LETTERS.
- In the case of a participant transferring between sites, it is recommended to maintain the same Participant Identification Number.
- Complete every line of every section, except for where the instructions say to skip a section based on certain responses.
- Selections with circles (O) are single selection answers (choose one answer only). Selections with square boxes (☐) are multiple selection answers (choose as many answers as are applicable).
- Mark 'N/A' for any results of laboratory values that are not available, not applicable or unknown.
- Avoid recording data outside of the dedicated areas. Sections are available for recording additional information.
- 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 participant together e.g. with a staple or participant-unique folder.
- Please transfer all paper CRF data to the electronic database. All paper CRFs needs to be stored locally, do not send any forms with patient identifiable information via e-mail or post except authorized by the MoH/GHS and authorized persons.

**PATIENTNT IDENTIFICATION #: [___][___][___]-- [___][___][___][___]**

# COVID-19 CASE REPORT FORM

**Data Collector's Details**

| | |
|---|---|
| Name: | |
| Facility name: | |
| Location (Region/Province/Country etc.) | |
| Telephone number: | |
| Email: | |

**Form Completion Date:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

## MODULE 1: PRESENTATION/ADMISSION

**Clinical Inclusion Criteria**

**Suspected or proven COVID-19 infection as main cause for admission:** O Suspected O Confirmed
**Samples taken** O YES O NO
**Date samples were taken:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
**Date results were received:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**Category of Case**

O New Case *(Prospective data)* O Current Admission *(retrospective and prospective data)*
O Discharged *(retrospective data only)* O Dead *(retrospective data only)*

**Demographics**

Date of Birth:: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_] Age: [___][___][___]years OR [___][___]months *(if < 12 months)*
Sex at birth: O Male O Female O Not specified
Home Address (with landmarks): _____
_____
_____
Country of Residence: _____
Nationality: _____
Educational Level Completed: O Basic O JHS O Middle School O Secondary (SHS/ Form 1-6)
O Tertiary (diploma and above) O Post Graduate O Other: _____
Patient's Occupation /Profession *(where they spend the most of their working time)*: _____
Patient's Occupation/ Profession *(major source of income)*: O same as above Other: Specify: _____
Location of Workplace: (with landmarks): _____
_____
_____
Employed as a Healthcare Worker? OYES ONO ON/A
Employed in a microbiology laboratory? OYES ONO ON/A

Ethinicity: *(select one only)*: O Arab O Black O East Asian O South Asian O West Asian O Latin American O White
O Aboriginal/First Nations O Other: _____ O Unknown



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ALERRT
African coaLition for Epidemic Research, Response and Training

PATIENTNT IDENTIFICATION #: [___][___][___]-- [___][___][___][___]

# COVID-19 CASE REPORT FORM

| **Case Pathway** *(facilities visited prior to arrival at current facility. Repeat for as many visits as required)* |
|---|
| Visit to healthcare facility or treatment resource O YES O NO |
| Name of healthcare facility or treatment resource: Location (Region/Province etc.): |
| Type: O Hospital/Clinic OPharmacy OMaternity home OHealthcare professional out of facility ON/A |
| Date of visit [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] O Unknown |

**Admission and Referral**

Contact with emergency number/ hotline O YES O NO
Date of emergency contact: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] O N/A
Admission date at this facility: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Time of admission (24-hr format):[_H_][_H_]/[_M_][_M_] OUnknown
Transfer from other facility? OYES ONO ON/A
If YES: Facility name:_____ Location (Region/Province etc.): _____
If YES: Reporting date at transferring facility *(DD/MM/YYYY)*: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ON/A
If YES: Participant ID # at transferring facility: OSame as current facility ODifferent: [___][___][___]–[___][___][___][___]

**Epidemiological Factors**

***In the 14 days before onset of illness had the patient any of the following:***

Travel (out of town/city) in the 14 days prior to first symptom onset? *(capture all travel events)* OYES ONO OUnknown
If Yes, specify location:_____ Location (Region/Province etc.)_____
Return Date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] O N/A

Close contact* with a confirmed or probable case of COVID-19 infection, while that patient was symptomatic O YES O NO O Unknown

Presence in a healthcare facility where COVID-19 infections have been managed O YES O NO O Unknown

Presence in a laboratory handling suspected or confirmed COVID-19 samples O YES O NO O Unknown

Direct contact with animals, raw meat or insect bites in the 14 days prior to symptom onset? O YES O NO O Unknown

*If YES, complete the ANIMAL EXPOSURE section*

** Close contact' is defined as:*
- *Health care associated exposure, including providing direct care for novel coronavirus patients, e.g. health care worker, working with health care workers infected with novel coronavirus, visiting patients or staying in the same close environment of a novel coronavirus patient, or direct exposure to body fluids or specimens including aerosols.*
- *Working together in close proximity or sharing the same classroom environment with a novel coronavirus patient.*
- *Traveling together with novel coronavirus patient in any kind of conveyance.*
- *Living in the same household as a novel coronavirus patient.*

**Pregnancy and Postpartum**

Pregnant? O YES O NO O Unknown O N/A If YES: Gestational weeks assessment: [___][___] weeks
POST PARTUM? OYES ONO O N/A *(if NO or N/A skip this section - go to INFANT)*
Pregnancy Outcome: OLive birth OStill birth Delivery date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**Infants and Children under 5 years of age only**

Infected infant *i.e. Less than 1 year old?* OYES ONO *(If NO skip this section)*
Birth weight: [___][___].[___]Okg or Olbs ON/A
Gestational outcome: O Term birth (≥37wk GA) OPreterm birth (<37wk GA) ON/A
Breastfed? OYES ONO ON/A If YES: OCurrently breastfed OBreastfeeding discontinued at [___][___]weeks☐N/A
Appropriate development for age? OYES ONO OUnknown
Vaccinations appropriate for age/country? OYES ONO OUnknown ON/A



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# COVID-19 CASE REPORT FORM

**Vaccination Information**

Child aged 5 years and below? O YES O NO O Unknown

*This should be completed for all children under 5 years old.*

All immunizations up to date for age of the child O YES O NO O Unknown

Confirmation from the Immunization records O YES O NO O Unknown

*If YES for both answers ignore the next Section*

*Complete this section if any of the question above were answered as NO or Unknown*

| Age | Vaccine | Given | Confirmation from Vaccination Records |
|---|---|---|---|
| At Birth | BCG | O YES O NO | O YES O NO |
| | OPV 0 | O YES O NO | O YES O NO |
| | Hepatitis B | O YES O NO | O YES O NO |
| 6 weeks | OPV 1 | O YES O NO | O YES O NO |
| | DPT/ Hep B/ Hib 1 | O YES O NO | O YES O NO |
| | Pneumococcal 1 | O YES O NO | O YES O NO |
| | Rotavirus 1 | O YES O NO | O YES O NO |
| 10 weeks | OPV 2 | O YES O NO | O YES O NO |
| | DPT/ Hep B/ Hib 2 | O YES O NO | O YES O NO |
| | Pneumococcal 2 | O YES O NO | O YES O NO |
| | Rotavirus 2 | O YES O NO | O YES O NO |
| 14 weeks | OPV 3 | O YES O NO | O YES O NO |
| | DPT/ Hep B/ Hib 3 | O YES O NO | O YES O NO |
| | Pneumococcal 3 | O YES O NO | O YES O NO |
| | IPV | O YES O NO | O YES O NO |
| 9 months | Measles-Rubella 1 | O YES O NO | O YES O NO |
| | Yellow Fever | O YES O NO | O YES O NO |
| 18months | Measles-Rubella 2 | O YES O NO | O YES O NO |
| | Meningitis A | O YES O NO | O YES O NO |
| | LLIN | O YES O NO | O YES O NO |

**Vitamin A Supplementation**

Vitamin A Supplementation up to date for age of the child O YES O NO O Unknown

Confirmation from the Supplementation records O YES O NO O Unknown

*If YES for both answers ignore the next Section*

*Complete this section if any of the question above were answered as NO or Unknown*

| Age (years) | 0.5 | 1 | 1.5 | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|---|---|---|
| Supplementation given | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO |
| Confirmation from supplementation records | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO |

**Deworming**

Deworming Records up to date for age of the child O YES O NO O Unknown

Confirmation from the Deworming records O YES O NO O Unknown

*If YES for both answers ignore the next Section*

*Complete this section if any of the question above were answered as NO or Unknown*

| Age (yrs) | 2 | 2.5 | 3 | 3.5 | 4 | 4.5 | 5 |
|---|---|---|---|---|---|---|---|
| Supplementation given | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO |
| Confirmation from supplementation records | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO | O YES O NO |



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# COVID-19 CASE REPORT FORM

## Signs and Symptoms Pre-Admission *(observed/reported prior to admission and associated with this episode of acute illness. Symptoms may/may not be present at time of interview)*

| | | *If Yes-Date of Onset* |
|---|---|---|
| History of fever | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Cough | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| *dry* | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| *with sputum production* | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| *bloody sputum/haemoptysis* | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Sore throat | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Runny nose (Rhinorrhoea) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Ear pain | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Wheezing | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Chest pain | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Muscle aches (Myalgia) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Joint pain (Arthralgia) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Fatigue / Tiredness | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Shortness of breath (dyspnea) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Anosmia (loss of smell) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Ageusia (loss of taste) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Headache | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Altered consciousness/confusion | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Seizures | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Abdominal pain | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Vomiting / Nausea | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Loss of speech or movement | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Diarrhoea | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Conjunctivitis | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Skin rash/discoloration | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Skin ulcers | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Oedema | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Palpitations | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Bleeding (Haemorrhage) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| If bleeding: specify site(s): | _____ | |
| | _____ | |
| | _____ | |
| Other Symptoms: | _____ | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Other Symptoms: | _____ | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |

## Pre-admission Medication: *(taken within 14 days of admission/ Presentation at the current health facility*

Angiotensin converting enzyme inhibitors (ACE inhibitors) O YES O NO O N/A

If YES, select ACE inhibitor

O Benazepril (Lotensin) O Captopril O Enalapril (Vasotec) O Fosinopril O Lisinopril (Prinivil, Zestril)
O Moexipril O Perindopril O Quinapril (Accupril) O Ramipril (Altace) O Trandolapril

Other, please provide type: _____

Select route for each ACE inhibitor: O Oral O Intravenous O Intramuscular

Angiotensin II receptor blockers (ARBs) O YES O NO O N/A

If YES, select ARB

O Candesartan (Atacand), O Eprosartan, O Irbesartan (Avapro), O Losartan (Cozaar), O Olmesartan (Benicar),
O Telmisartan (Micardis), O Valsartan (Diovan), O Azilsartan (Edarbi)

Other, please provide type: _____

Select route for each ARB: O Oral O Intravenous O Intramuscular

Non-steroidal anti-inflammatory (NSAIDs) O YES O NO O N/A

If YES, please provide type: _____

Select route for each NSAID: O Oral O Intravenous O Intramuscular



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# COVID-19 CASE REPORT FORM

Oral steroid? OYES ONO ON/A
If YES, please provide type: _____

Other immunosuppressant agents
*(not oral steroids)* OYES ONO ON/A
If YES, please provide type: _____
Select route for each immunosuppressant agent: OOral OIntravenous OIntramuscular

Hydroxychloroquine? OYES ONO ON/A
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days OUnknown
Route: OOral OIntravenous OIntramuscular

Chloroquine phosphate? OYES ONO ON/A
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days OUnknown
Route: OOral OIntravenous OIntramuscular

Azithromycin? OYES ONO ON/A
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days OUnknown
Route: OOral OIntravenous OIntramuscular

Antiviral agent? OYES ONO ON/A If YES: ☐Ribavirin ☐Lopinavir/Ritonavir ☐Interferon alpha ☐Interferon beta ☐ Neuraminidase inhibitor ☐Other _____

Other Antibiotic? OYES ONO ON/A
If YES, please provide type: _____
Select route for each antibiotic agent: OOral OIntravenous OIntramuscular

Antipyretic *(excluding NSAIDs)*? OYES ONO ON/A
If YES, please provide type: _____
Select route for each antipyretic: OOral OIntravenous OIntramuscular

Other targeted COVID-19 Medications
(*repeat as many times as necessary)*? OYES ONO ON/A
If YES, please provide type: _____

| **Co-morbidities and risk factors** *(patient reported or recorded)* | | | |
|---|---|---|---|
| Hypertension | OYES ONO OUnknown | Sickle Cell Disease | OYES ONO OUnknown |
| Chronic cardiac disease, including congenital heart disease *(not hypertension)* | OYES ONO OUnknown | Obesity *(as defined by clinical staff)* | OYES ONO OUnknown |
| Chronic pulmonary disease *(not asthma)* | OYES ONO OUnknown | BMI *(to be generated automatically)* | OYES ONO OUnknown |
| Asthma *(physician diagnosed)* | OYES ONO OUnknown | Diabetes with complications | OYES ONO OUnknown |
| Chronic kidney disease | OYES ONO OUnknown | Diabetes without complications | OYES ONO OUnknown |
| Moderate or severe liver disease | OYES ONO OUnknown | Rheumatologic disorder | OYES ONO OUnknown |
| Mild liver disease | OYES ONO OUnknown | Dementia | OYES ONO OUnknown |
| Organ or bone marrow recipient | OYES ONO OUnknown | Malnutrition | OYES ONO OUnknown |
| Chronic neurological impairment/disease | OYES ONO OUnknown If YES specify_____ | Smoking | OYES *(within past 12months)* ONever smoked OFormer smoker *(more than 12 months ago)* |
| Malignant neoplasm | OYES ONO OUnknown If YES specify_____ | If "Yes" or "former smoker" to smoking, how many sticks? _____ OPer week OPer day | |
| Chronic hematologic disease | OYES ONO OUnknown If YES specify_____ | Alcohol | OYES *(within past 3 months)* ONever used alcohol OFormer alcohol user *(more than 3 months ago)* |
| AIDS / HIV | OYES ONO OUnknown | | |
| Other relevant risk factor OYES ONO OUnknown (*repeat as many times as necessary)* If yes, specify:_____ | | | |



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PATIENTNT IDENTIFICATION #: [___][___][___]-- [___][___][___][___]

# COVID-19 CASE REPORT FORM

## Vitals at Hospital or Isolation Center Admission *(first available data at presentation/admission)*

Temperature: [_ ][_ ].[_ ]°C HR: [_ ][_ ][_ ]beats per minute RR: [_ ][_ ]breaths per minute

Systolic BP: [_ ] [_ ] [_ ]mmHg Diastolic BP: [_ ][_ ][_ ]mmHg

Weight: [_ ] [_ ] [_ ] . [_ ]Kg Height: [_ ] [_ ] [_ ] . [_ ] m

Capillary refill time >2seconds O YES O NO O Unknown

Oxygen saturation: [_ ][_ ][_ ]% On: O Room air O Oxygen therapy

Any supplemental oxygen: $FiO_2$ *(0.21-1.0)* [___].[___][___] or [___][___] % or [___][___]L/min

## During Admission Signs and Symptoms *(repeat for as many days as required)*

| | | *If Yes-Date* |
|---|---|---|
| Fever | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Cough | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| *dry* | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| *with sputum production* | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| *bloody sputum/haemoptysis* | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Sore throat | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Runny nose (Rhinorrhoea) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Ear pain | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Wheezing | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Chest pain | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Muscle aches (Myalgia) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Joint pain (Arthralgia) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Fatigue / Tiredness | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Shortness of breath (dyspnea) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Anosmia (loss of smell) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Ageusia (loss of taste) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Lower chest wall indrawing | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Headache | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Altered consciousness/confusion | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Seizures | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Abdominal pain | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Vomiting / Nausea | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Loss of speech or movement | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Diarrhoea | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Conjunctivitis | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Skin rash/discoloration | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Skin ulcers | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Lymphadenopathy | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Oedema | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Palpitations | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Bleeding (Haemorrhage) | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| If bleeding: specify site(s): | _____ | |
| | _____ | |
| | _____ | |
| Other Symptoms: | _____ | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Other Symptoms: | _____ | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Clinical pneumonia diagnosed? | O YES O NO O Unknown | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |



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# COVID-19 CASE REPORT FORM

## MODULE 2: RECURRENT CLINICAL ASSESSMENTS

**Recurrent Vitals Records** *(to be completed at any time vitals are recorded)*
**Date of Assessment** *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
**Time of Assessment** *(24-hr format):*[_H_][_H_]/[_M_][_M_]

Done ○YES ○NO Glasgow Coma SGHS (GCS / 15) [___][___]
Done ○YES ○NO Temperature: [_ ] [_ ][_ ].[_ ] ○°C *or* ○ °F
Done ○YES ○NO HR: [_ ][_ ][_ ]beats per minute
Done ○YES ○NO RR: [_ ][_ ]breaths per minute
Done ○YES ○NO Systolic BP: [_ ] [_ ] [_ ]mmHg Diastolic BP: [_ ][_ ][_ ]mmHg
Done ○YES ○NO Capillary refill time >2seconds ○YES ○NO ○Unknown
Done ○YES ○NO Oxygen saturation: [_ ][_ ][_ ]% On: ○Room air ○Oxygen therapy ○N/A

**Recurrent ICU/ITU/IMC/HDU Records** *(to be completed at any time vitals are recorded)*
**Date of Assessment** *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
**Time of Assessment** *(24-hr format):*[_H_][_H_]/[_M_][_M_]

Current admission to ICU/ITU/IMC/HDU? ○YES ○NO
Done ○YES ○NO $FiO_2$ *(0.21-1.0)* [___].[___][___] or [___][___]L/min
Done ○YES ○NO $PaO_2$ *at time of* $FiO_2$ *above* [___][___][___]○kPa *or* ○mmHg
Done ○YES ○NO $PaO_2$ sample type: ○ Arterial ○ Venous ○ Capillary ○N/A
Done ○YES ○NO From same blood gas record as $PaO_2$ $PCO_2$ _____○kPa *or* ○mmHg
Done ○YES ○NO pH _____
Done ○YES ○NO $HCO_3$- _____mEq/L
Done ○YES ○NO Base excess _____ mmol/L
Done ○YES ○NO Urine flow rate [___][___][___][___][___]mL/24 hours ☐ Check if estimated
Is the patient currently receiving, or has received *(apply to all questions in this section)*:
High-flow nasal canula oxygen therapy ○YES ○NO ○N/A
Non-invasive ventilation *(e.g. BIPAP, CPAP)*? ○YES ○NO ○N/A
Invasive ventilation? ○YES ○NO ○N/A
Extra corporeal life support (ECLS)? ○YES ○NO ○N/A
Dialysis/Hemofiltration? ○YES ○NO ○N/A
Any vasopressor/inotropic support? ○ YES ○ NO *(if NO, answer the next 3 questions NO)* ○N/A
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/kg/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: ○YES ○NO
Neuromuscular blocking agents? ○YES ○NO ○N/A
Inhaled Nitric Oxide? ○YES ○NO ○N/A
Tracheostomy inserted? ○YES ○NO ○N/A
Prone positioning? ○YES ○NO ○N/A
Other intervention or procedure: ○YES ○NO ○N/A If YES, Specify: _____
_____



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# COVID-19 CASE REPORT FORM

## Laboratory Results *(repeat for as many samples taken)*

HAEMATOLOGY
DATE OF SAMPLING *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
Time of sampling (24-hr format):[_H_][_H_]/[_M_][_M_]
Done O YES O NO Haemoglobin _____ O g/L *or* O g/dL
Done O YES O NO WBC count _____ O $x10^9$/L *or* O $x10^3$/µL
Done O YES O NO Lymphocyte count _____ _____ O cells/ µL
Done O YES O NO Neutrophil count _____ _____ O cells/ µL
Done O YES O NO Haematocrit [___][___]%
Done O YES O NO Platelets _____ O $x10^9$/L *or* O $x10^3$/µL
Done O YES O NO APTT/APTR _____
Done O YES O NO PT _____ seconds
Done O YES O NO INR_____
Done O YES O NO G6PD O No defect O Partial defect O Full defect
Done O YES O NO HB Electrophoresis: ☐HbA ☐HbF ☐HbS ☐HbC ☐HbE ☐Other_____

PREGNANCY TEST
DATE OF SAMPLING *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
Time of sampling (24-hr format):[_H_][_H_]/[_M_][_M_]
Done O YES O NO URINE PREGNANCY TEST (TOTA ßhCG --- URINE) O Positive O Negative

BIOCHEMISTRY
DATE OF SAMPLING *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
Time of sampling (24-hr format):[_H_][_H_]/[_M_][_M_]
Done O YES O NO ALT/SGPT _____ U/L
Done O YES O NO ALP _____ U/L
Done O YES O NO GGT _____ U/L
Done O YES O NO Total Protein _____ U/L
Done O YES O NO Albumin _____ U/L
Done O YES O NO Globulin _____ U/L
Done O YES O NO Total Bilirubin _____ O µmol/L *or* O mg/dL
Done O YES O NO AST/SGOT _____ U/L
Done O YES O NO Glucose _____ O mmol/L *or* O mg/dL

Done O YES O NO Blood Urea Nitrogen (urea) _____ O mmol/L *or* O mg/dL
Done O YES O NO Creatinine _____ O µmol/L *or* O mg/dL
Done O YES O NO Sodium [___][___][___][___] mEq/L
Done O YES O NO Potassium [___][___].[___] mEq/L

Done O YES O NO hs-CRP_[___][___][___].[___]_mg/L
Done O YES O NO HBA1C: _____%

Done O YES O NO Total Cholesterol _____mmol/L
Done O YES O NO Triglycerides _____mmol/L
Done O YES O NO HDL _____mmol/L
Done O YES O NO LDL _____mmol/L
Done O YES O NO VLDL _____mmol/L
Done O YES O NO Coronary Risk_____ (number)



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MALARIA MICROSCOPY
Done ○YES ○NO _____ parasites/hpf

URINE R/E
DATE OF SAMPLING *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
Time of sampling (24-hr format):[_H_][_H_]/[_M_][_M_]
Done ○YES ○NO Color: ○Clear ○ light Yellow ○Yellow ○Dark Yellow ○Amber ○Brown ○Red
Done ○YES ○NO Appearance: ○Clear ○Cloudy ○Blood Stained ○Flank Blood
Done ○YES ○NO Glucose: ○Positive ○Negative
Done ○YES ○NO Bilirubin: ○Positive ○Negative
Done ○YES ○NO Ketone: ○Positive ○Negative
Done ○YES ○NO Spec. Gravity:_____ (number)
Done ○YES ○NO Blood: ○Positive ○Negative
Done ○YES ○NO pH:_____
Done ○YES ○NO Protein: ○Positive ○Negative
Done ○YES ○NO Urobilinogen: ○Positive ○Negative
Done ○YES ○NO Nitrite ○Positive ○Negative
Done ○YES ○NO Leukocytes: ○Positive ○Negative
Done ○YES ○NO Urine Microscopy:
RBC: _____ (number)
WBC: _____ (number)
Epithelial Cells: _____ (number)
Bacteria: _____ (number)

STOOL R/E
DATE OF SAMPLING *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
Time of sampling (24-hr format):[_H_][_H_]/[_M_][_M_]
Done ○YES ○NO
Color: ○ Brown ○ Black ○ Pale ○ Red/Blood Stained ○ Green ○Yellow ○other: _____
Form & Consistency: ○ Well-formed ○Loose ○ Mucoid ○other:_____
Reaction:
Charcot- Leyden Crystals: ○Present ○Absent If Present quantify_____
Pus cells: ○Present ○Absent If Present quantify_____
RBC: ○Present ○Absent If Present quantify_____
Macrophages: ○Present ○Absent If Present quantify_____
Protozoal parasites: ○Present ○Absent If Present quantify_____
Helminthic ova: ○Present ○Absent If Present quantify_____
Other observations: _____

SEROLOGY
Done ○YES ○NO Hepatitis A (screening) ○Positive ○Negative
Done ○YES ○NO Hepatitis B (screening) ○Positive ○Negative
Done ○YES ○NO Hepatitis C (screening) ○Positive ○Negative
Done ○YES ○NO Hepatitis D (screening) ○Positive ○Negative
Done ○YES ○NO Hepatitis E (screening) ○Positive ○Negative

Done ○YES ○NO HIV 1&2 (screening) ○Positive ○Negative

IMAGING
Chest X-Ray performed? OYES ONO ON/A
DATE OF IMAGING *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
Time of imaging (24-hr format):[_H_][_H_]/[_M_][_M_]
If Yes: were any abnormalities seen? OYES ONO
Lung involvement: Ounilateral Obilateral

If bilateral; location of abnormalities Osymmetrical Oasymmetrical
If Yes: Were infiltrates present (select all that apply) ☐ ground-glass ☐ air-space consolidation ☐ reticular
Distribution of abnormalities Operipheral Ocentral Omultilobar

Associated findings (select all that apply) ☐ mediastinal masses/lymphadenopathy ☐ pleural effusion ☐ pneumothorax
Other findings on CXR (select all that apply) ☐ cardiomegaly ☐aortic calcification ☐ tumours

Other Imaging performed? _____ OYES ONO ON/A
If yes, select imaging performed OCT Scan OUltrasound OMRI
DATE OF IMAGING *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_]
Time of imaging (24-hr format):[_H_][_H_]/[_M_][_M_]
If Yes: Attach report of imaging

## MODULE 3: OUTCOMES

**Treatment: At ANY time during hospitalization, did the patient receive/ undergo:**

Is the patient currently receiving, or has received *(apply to all questions in this section)*:

High-flow nasal canula oxygen therapy OYES ONO ON/A If YES, total duration: _____days
Non-invasive ventilation *(e.g. BIPAP, CPAP)*? OYES ONO ON/A If YES, total duration: _____days
Invasive ventilation? OYES ONO ON/A If YES, total duration: _____days
Prone positioning? OYES ONO ON/A If YES, total duration: _____days
Extra corporeal life support (ECLS)? OYES ONO ON/A If YES, total duration: _____days
Dialysis/Hemofiltration? OYES ONO ON/A
Any vasopressor/inotropic support? OYES ONO *(if NO, answer the next 3 questions NO)* ON/A
If Yes, State duration: _____ days *(repeat for each that is positive)*
Dopamine <5µg/kg/min OR Dobutamine OR milrinone OR levosimendan: OYES ONO
Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine: OYES ONO
Dopamine >15µg/kg/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: OYES ONO
Neuromuscular blocking agents? OYES ONO ON/A
Inhaled Nitric Oxide? OYES ONO ON/A
Tracheostomy inserted? OYES ONO ON/A
Other intervention or procedure: OYES ONO ON/A If YES, Specify:
ICU or High Dependency Unit admission? OYES ONO ON/A If YES, total duration: _____days
If Yes, date of ICU admission: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
date of ICU discharge: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**Pathogen Testing** *(repeat for as many samples taken)*

| Date | Biospecimen Type | Laboratory test Method | Pathogen | Specimen Shipped to other Laboratory for confirmation |
|---|---|---|---|---|
| *(DD/MM/YYYY):* [_D_][_D_]/[_M_][_M_]/[__2_][__0_][_Y_][_Y_] **Time (24-hr format):**[_H_][_H_]/[_M_][_M_] | OBlood<br>ONasal/NP swab<br>OThroat swab<br>OCombined nasal/NP+throat swab<br>OSputum<br>OOther, *Specify:* _____ | OPCR<br>OCulture<br>OOther, *Specify:* _____ | OPositive<br>ONegative<br>If Positive specify:<br>1.<br>2.<br>3.<br>4.<br>5. | OYES ONO |



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# COVID-19 CASE REPORT FORM

| **Complications:** ***At any time during hospitalisation did the patient experience:*** | | |
|---|---|---|
| | | ***If Yes-Date*** |
| Viral pneumonitis | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Bacterial pneumonia | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Acute Respiratory Distress Syndrome | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Pneumothorax | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Pleural effusion | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Cryptogenic organizing pneumonia (COP) | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Bronchiolitis | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Meningitis / Encephalitis | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Seizure | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Stroke / Cerebrovascular accident | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Congestive heart failure | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Endocarditis / Myocarditis / Pericarditis | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Cardiac arrhythmia | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Cardiac ischemia | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Cardiac arrest | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Bacteremia | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Coagulation disorder / Disseminated Intravascular Coagulation | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Anaemia<br>*If yes, specify:* ☐*Mild* ☐*Moderate* ☐*Severe* | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Rhabdomyolysis / Myositis | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Acute renal injury/ Acute renal failure | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Gastrointestinal haemorrhage | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Pancreatitis | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Liver dysfunction | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Hyperglycemia | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Hypoglycemia | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Other: _____ | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |



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# COVID-19 CASE REPORT FORM

## Medication: *While hospitalised or at discharge, were any of the following administered:*

Antiviral agent? ○YES ○NO ○N/A
If YES specific all the agents and duration

☐Ribavirin Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
☐Lopinavir/Ritonavir Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
☐Interferon alpha Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
☐Interferon beta Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
☐ Neuraminidase inhibitor Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
☐Other _____ Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk

Hydroxychloroquine ? ○YES ○NO ○N/A
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route: ○Oral ○Intravenous ○Intramuscular

Chloroquine phosphate? ○YES ○NO ○N/A
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route: ○Oral ○Intravenous ○Intramuscular

Azithromycin? ○YES ○NO ○N/A
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route: ○Oral ○Intravenous ○Intramuscular

Antibiotic *(repeat for as many antibiotics as required)*? ○YES ○NO ○N/A
If YES specify all the agents and duration,
Agent: _____ Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route: ○Oral ○Intravenous ○Intramuscular

Antipyretic *(repeat for as many antipyretics as required)*? ○YES ○NO ○N/A
If YES specify all the agents and duration,
Agent: _____ Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route: ○Oral ○Intravenous ○Intramuscular

Corticosteroid? ○YES ○NO ○N/A
If YES specify the agents and duration,
Agent: _____ Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route:○Oral ○Intravenous ○Intramuscular

Heparin? ○YES ○NO ○N/A
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route:○Subcutaneous ○Intravenous ○Intramuscular

Others (*repeat as many times as necessary)*? ○YES ○NO ○N/A
If YES specify all the agents and duration,
Agent: _____ Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days ○Unk
Route:○Oral ○Intravenous ○Intramuscular



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# COVID-19 CASE REPORT FORM

## Outcome

Outcome date: [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Outcome: O Discharged O Recovered (confirmed by Negative COIVD-19 test) OTransferred to other facility ODied
O Discharged to continue home-based care OPalliative discharge

Results of COVID-19 PCR test at discharge: O Positive O Negative O Unknown
If Discharged alive; ability to self-care at discharge versus before illness: O Same as before illness O Worse O Better O N/A
If Discharged alive; post-discharge treatment:
Oxygen therapy? O YES O NO O N/A Dialysis/renal treatment? O YES O NO O N/A
Other intervention or procedure? O YES O NO O N/A
If YES: Specify *(multiple permitted):* _____
If Transferred: : Facility name:_____ Location (Region/Province etc.): _____
If Transferred: Is the transfer facility a study site? O YES O NO O N/A
If a Study Site: Participant ID# at new facility: O Same as above O Different: [___][___][___] – [___][___][___][___] O N/A

Diagnosis:
1.
2.
3.
4.
5.



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# COVID-19 CASE REPORT FORM

## SUPPLEMENTARY FORM 1

**Kessler Psychological Distress Scale (K10)**

Scale completed: O YES O NO

*Complete all the questions in the scale Each item is scored from 1 'none of the time' to 5 'all of the time'. Scores of the 10 items are then summed, yielding a minimum score of 10 and a maximum score of 50.*

| Question Number | **Please tick the answer that is correct for you** | **All of the time** | **Most of the time** | **Some of the time** | **A little of the time** | **None of the time** |
|---|---|---|---|---|---|---|
| | | (score 5) | (score 4) | (score 3) | (score 2) | (score 1) |
| **1** | In the past 4 weeks, about how often did you feel tired out for no good reason? | | | | | |
| **2** | In the past 4 weeks, about how often did you feel nervous? | | | | | |
| **3*** | In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down? | | | | | |
| **4** | In the past 4 weeks, about how often did you feel hopeless? | | | | | |
| **5** | In the past 4 weeks, about how often did you feel restless or fidgety? | | | | | |
| **6*** | In the past 4 weeks, about how often did you feel so restless you could not sit still? | | | | | |
| **7** | In the past 4 weeks, about how often did you feel depressed? | | | | | |
| **8** | In the past 4 weeks, about how often did you feel that everything was an effort? | | | | | |
| **9** | In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up? | | | | | |
| **10** | In the past 4 weeks, about how often did you feel worthless? | | | | | |

**Questions 3 (three) and 6 (six) if the response to the preceding question was 'none of the time'. In such cases questions 3 (three) and 6 (six) should receive an automatic score of 1 (one)*

Total Score: _____out of 50

**Interpretation of score**

K10 Score: Likelihood of having a mental disorder (psychological distress)

O 10 - 19 Likely to be well
O 20 - 24 Likely to have a mild disorder
O 25 - 29 Likely to have a moderate disorder
O 30 - 50 Likely to have a severe disorder

# COVID-19 CASE REPORT FORM

## SUPPLEMENTARY FORM 2

| **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?** O YES O NO O N/A If yes, *complete each line below.* *If YES, specify the animal/insect, type of contact and date of exposure (DD/MM/YYYY) here:* ⬇ | | |
|---|---|---|
| Bird/Aves (e.g. chickens, turkeys, ducks) | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Bat | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Livestock (e.g. goats, cattle, camels) | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Horse | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Rabbit / Hare | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Pigs | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Non-human primates | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Rodent (e.g. rats, mice, squirrels) | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Insect or tick bite (e.g. tick, flea, mosquito) | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Reptile / Amphibian | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Domestic animals living in his/her home (e.g. cats, dogs, other) | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Animal faeces or nests | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Sick animal or dead animal | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Raw animal meat / animal blood | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Skinned, dressed or eaten wild game | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Visit to live animal market, farm or zoo | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Participated in animal surgery or necropsy | O YES O NO O N/A | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Other animal contacts: | _____<br>_____<br>_____<br>_____ | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]<br>[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]<br>[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]<br>[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |

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