ALERRT
African coaLition for Epidemic Research, Response and Training

PATIENT 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.

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PATIENT 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 None 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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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 *(< 6 weeks after delivery)*? 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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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

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

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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Oral steroid? O YES O NO O N/A
If YES, please provide type: _____

Other immunosuppressant agents
(not oral steroids) O YES O NO O N/A
If YES, please provide type: _____
Select route for each immunosuppressant agent: O Oral O Intravenous O Intramuscular

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

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

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

Antiviral agent? O YES O NO O N/A If YES: ☐ Ribavirin ☐ Lopinavir/Ritonavir ☐ Interferon alpha ☐ Interferon beta
☐ Neuraminidase inhibitor ☐ Other _____

Other Antibiotic? O YES O NO O N/A
If YES, please provide type: _____
Select route for each antibiotic agent: O Oral O Intravenous O Intramuscular

Antipyretic *(excluding NSAIDs)*? O YES O NO O N/A
If YES, please provide type: _____
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days O Unknown
Select route for each antipyretic: O Oral O Intravenous O Intramuscular

Other targeted COVID-19 Medications
(*repeat as many times as necessary)*? O YES O NO O N/A
If YES, please provide type: _____
Date commenced [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Duration: _____ days O Unknown
Select route for each antipyretic: O Oral O Intravenous O Intramuscular Route: O Oral O Intravenous O Intramuscular

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Co-morbidities and risk factors *(patient reported or recorded)*			
Hypertension	O YES O NO O Unknown	Sickle Cell Disease	O YES O NO O Unknown
Chronic cardiac disease, including congenital heart disease *(not hypertension)*	O YES O NO O Unknown	Obesity *(as defined by clinical staff)*	O YES O NO O Unknown
Chronic pulmonary disease *(not asthma)*	O YES O NO O Unknown	BMI *(to be generated automatically)*	
Asthma *(physician diagnosed)*	O YES O NO O Unknown	Diabetes with complications	O YES O NO O Unknown
Chronic kidney disease	O YES O NO O Unknown	Diabetes without complications	O YES O NO O Unknown
Moderate or severe liver disease	O YES O NO O Unknown	Rheumatologic disorder	O YES O NO O Unknown
Mild liver disease	O YES O NO O Unknown	Dementia	O YES O NO O Unknown
Organ or bone marrow recipient	O YES O NO O Unknown	Malnutrition	O YES O NO O Unknown
Tuberculosis	O YES O NO O Unknown	Malaria	O YES O NO O Unknown
Asplenia	O YES O NO O Unknown		
Chronic neurological impairment/disease	O YES O NO O Unknown If YES specify_____	Smoking	O YES *(within past 12months)* O Never smoked O Former smoker *(more than 12 months ago)*
Malignant neoplasm	O YES O NO O Unknown If YES specify_____	If "Yes" or "former smoker" to smoking, how many sticks? _____ O Per week O Per day	
Chronic hematologic disease	O YES O NO O Unknown If YES specify_____	Alcohol	O YES *(within past 3 months)* O Never used alcohol O Former alcohol user *(more than 3 months ago)*
AIDS / HIV	O YES O NO O Unknown		

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Other relevant risk factor O YES O NO O Unknown *(repeat as many times as necessary)*

If yes, specify:_____

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 MUAC (Up to 5 years of age): [_] [_] . [_]cm

Capillary refill time >2seconds O YES O NO O Unknown (GCS / 15) [___][___] **OR** (BCS / 5) [___] If 5 years or less

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

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

MODULE 2: RECURRENT CLINICAL ASSESSMENTS

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_]

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COVID-19 CASE REPORT FORM

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_]

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 O YES O NO Glasgow Coma SGHS (GCS / 15) [___][___] **OR** (BCS / 5) [___] if 5 years or less
Done O YES O NO Temperature: [_][_][_].[_] O °C *or* O °F
Done O YES O NO HR: [_][_][_]beats per minute
Done O YES O NO RR: [_][_]breaths per minute
Done O YES O NO Systolic BP: [_] [_] [_]mmHg Diastolic BP: [_][_][_]mmHg
Done O YES O NO Capillary refill time >2seconds O YES O NO O Unknown
Done O YES O NO Oxygen saturation: [_][_][_]% On: O Room air O Oxygen therapy O 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? O YES O NO
Done O YES O NO FiO_2 *(0.21-1.0)* [___].[___][___] or [___][___]L/min
Done O YES O NO PaO_2 *at time of* FiO_2 *above* [___][___][___] O kPa *or* O mmHg
Done O YES O NO PaO_2 sample type: O Arterial O Venous O Capillary O N/A
Done O YES O NO From same blood gas record as PaO_2 PCO_2 _____ O kPa *or* O mmHg
Done O YES O NO pH _____
Done O YES O NO HCO_3- _____mEq/L
Done O YES O NO Base excess _____ mmol/L
Done O YES O 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 O YES O NO O N/A
Non-invasive ventilation *(e.g. BIPAP, CPAP)*? O YES O NO O N/A
Invasive ventilation? O YES O NO O N/A
Extra corporeal life support (ECLS)? O YES O NO O N/A
Dialysis/Hemofiltration? O YES O NO O N/A
Any vasopressor/inotropic support? O YES O NO *(if NO, answer the next 3 questions NO)* O N/A
Dopamine <5µg/kg/min OR Dobutamine OR milrinone OR levosimendan: O YES O NO
Dopamine 5-15µg/kg/min OR Epinephrine/Norepinephrine < 0.1µg/kg/min OR vasopressin OR phenylephrine: O YES O NO
Dopamine >15µg/kg/min OR Epinephrine/Norepinephrine > 0.1µg/kg/min: O YES O NO
Neuromuscular blocking agents? O YES O NO O N/A
Inhaled Nitric Oxide? O YES O NO O N/A
Tracheostomy inserted? O YES O NO O N/A
Prone positioning? O YES O NO O N/A
Other intervention or procedure: O YES O NO O N/A If YES, Specify: _____
_____

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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 ❍YES ❍NO Haemoglobin _____ ❍g/L *or* ❍g/dL
Done ❍YES ❍NO WBC count _____ ❍x10^9/L *or* ❍x10^3/µL
Done ❍YES ❍NO Lymphocyte count _____ _____ ❍cells/ µL
Done ❍YES ❍NO Neutrophil count _____ _____ ❍ cells/ µL
Done ❍YES ❍NO Haematocrit [___][___]%
Done ❍YES ❍NO Platelets _____ ❍x10^9/L *or* ❍x10^3/µL
Done ❍YES ❍NO Eosinophils _____ ❍x10^9/L *or* ❍x10^3/µL
Done ❍YES ❍NO APTT/APTR _____
Done ❍YES ❍NO PT _____ seconds
Done ❍YES ❍NO INR_____
Done ❍YES ❍NO G6PD ❍No defect ❍Partial defect ❍Full defect
Done ❍YES ❍NO HB Electrophoresis: ☐HbA ☐HbF ☐HbS ☐HbC ☐HbE ☐Other_____
Done ❍YES ❍NO D-Dimer ☐ Positive ☐ Negative
Done ❍YES ❍NO Fibrinogen [___][___].[___] g/l
Done ❍YES ❍NO Ferritin [___][___].[___] µg/l

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 ❍YES ❍NO URINE PREGNANCY TEST (TOTA ßhCG --- URINE) ❍Positive ❍Negative

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COVID-19 CASE REPORT FORM

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 ○YES ○NO ALT/SGPT _____ U/L
Done ○YES ○NO ALP _____ U/L
Done ○YES ○NO GGT _____ U/L
Done ○YES ○NO Total Protein _____ U/L
Done ○YES ○NO Albumin _____ U/L
Done ○YES ○NO Globulin _____ U/L
Done ○YES ○NO Total Bilirubin _____○µmol/L *or* ○mg/dL
Done ○YES ○NO AST/SGOT _____ U/L
Done ○YES ○NO Fasting Glucose _____○mmol/L *or* ○mg/dL
Done ○YES ○NO Procalcitonin [___][___].[___] µg/l
Done ○YES ○NO Blood Urea Nitrogen (urea) _____ ○mmol/L *or* ○mg/dL
Done ○YES ○NO Creatinine _____ ○µmol/L *or*○mg/dL
Done ○YES ○NO Sodium [___][___][___][___] mEq/L
Done ○YES ○NO Potassium [___][___].[___] mEq/L

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

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

- Done ○YES ○NO Cytokine profile
  - ☐ **IL-1b**[___][___][___].[___] pg/ml ☐ **IL-1RA** [___][___][___].[___]pg/ml ☐ **IL-2R** [___][___][___].[___] pg/ml
  - ☐ **IL-6** [___][___][___].[___] pg/ml ☐ **IL-8** [___][___][___].[___] pg/ml ☐ **IL-10** [___][___][___].[___]pg/ml
  - ☐ **IL-18** [___][___][___].[___] pg/ml ☐ **TNF** [___][___][___].[___]pg/ml
- ☐ **Other cytokines** (Specify): [___][___][___].[___] pg/ml

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COVID-19 CASE REPORT FORM

MALARIA MICROSCOPY
Done O YES O NO _____ parasites/hpf
MALARIA RDT: Done O YES O NO If YES: O POSITIVE O NEGATIVE

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 O YES O NO Color: O Clear O light Yellow O Yellow O Dark Yellow O Amber O Brown O Red
Done O YES O NO Appearance: O Clear O Cloudy O Blood Stained O Frank Blood
Done O YES O NO Glucose: O Positive O Negative
Done O YES O NO Bilirubin: O Positive O Negative
Done O YES O NO Ketone: O Positive O Negative
Done O YES O NO Spec. Gravity:_____ (number)
Done O YES O NO Blood: O Positive O Negative
Done O YES O NO pH:_____
Done O YES O NO Protein: O Positive O Negative
Done O YES O NO Urobilinogen: O Positive O Negative
Done O YES O NO Nitrite O Positive O Negative
Done O YES O NO Leukocytes: O Positive O Negative
Done O YES O NO Urine Microscopy:
RBC: _____ (number)
WBC: _____ (number)
Epithelial Cells: _____ (number)
Bacteria: _____ (number)
Schisotosoma Ova O Seen O Not seen

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 O YES O NO
Color: O Brown O Black O Pale O Red/Blood Stained O Green O Yellow O other: _____
Form & Consistency: O Well-formed O Loose O Mucoid O other:_____
Reaction:
Charcot- Leyden Crystals: O Present O Absent If Present quantify_____
Pus cells: O Present O Absent If Present quantify_____
RBC: O Present O Absent If Present quantify_____
Macrophages: O Present O Absent If Present quantify_____
Protozoal parasites: O Present O Absent If Present quantify_____
Helminthic ova: O Present O Absent If Present quantify_____
Strongyloides larvae: O Present O Absent If Present quantify_____
Schistosoma ova: O Present O Absent If Present quantify_____
Other observations: _____

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

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

Done O YES O NO Strongyloides serology (IgG) O Positive O Negative

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IMAGING
Chest X-Ray performed? ❍YES ❍NO ❍N/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? ❍YES ❍NO
Lung involvement: ❍unilateral ❍bilateral

If bilateral; location of abnormalities ❍symmetrical ❍asymmetrical
If Yes: Were infiltrates present (select all that apply) ☐ ground-glass ☐ air-space consolidation ☐ reticular
Distribution of abnormalities ❍peripheral ❍central ❍multilobar ❍Apex ❍Lung Bases ❍Other(specify)_____
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? _____ ❍YES ❍NO ❍N/A
If yes, select imaging performed ❍CT Scan ❍Ultrasound ❍MRI
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)*:
Blood Transfusion (Select all that apply below)
Whole blood ❍YES ❍NO Packed cells ❍YES ❍NO FFPs ❍YES ❍NO Platelets ❍YES ❍NO
High-flow nasal canula oxygen therapy ❍YES ❍NO ❍N/A If YES, total duration: _____days
Non-invasive ventilation *(e.g. BIPAP, CPAP)*? ❍YES ❍NO ❍N/A If YES, total duration: _____days
Invasive ventilation? ❍YES ❍NO ❍N/A If YES, total duration: _____days
Prone positioning? ❍YES ❍NO ❍N/A If YES, total duration: _____days
Extra corporeal life support (ECLS)? ❍YES ❍NO ❍N/A If YES, total duration: _____days
Dialysis/Hemofiltration? ❍YES ❍NO ❍N/A
Any vasopressor/inotropic support? ❍YES ❍NO *(if NO, answer the next 3 questions NO)* ❍N/A
If Yes, State duration: _____ days *(repeat for each that is positive)*
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
Other intervention or procedure: ❍YES ❍NO ❍N/A If YES, Specify:
ICU or High Dependency Unit admission? ❍YES ❍NO ❍N/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_]	❍Blood ❍Nasal/NP swab ❍Throat swab ❍Combined nasal/NP+throat swab ❍Sputum ❍Other, *Specify:* _____	❍PCR ❍Culture ❍Other, *Specify:* _____	❍Positive ❍Negative If Positive specify: 1. 2. 3. 4. 5.	❍YES ❍NO

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COVID-19 CASE REPORT FORM

Complications: ***At any time during hospitalisation did the patient experience:*** ***UNK=UNKNOWN***		***If Yes-Date***
Viral pneumonitis	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Bacterial pneumonia	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Acute Respiratory Distress Syndrome	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Pneumothorax	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Pleural effusion	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Cryptogenic organizing pneumonia (COP)	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Bronchiolitis	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Meningitis / Encephalitis	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Seizure	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Stroke / Cerebrovascular accident	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Congestive heart failure	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Endocarditis / Myocarditis / Pericarditis	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Cardiac arrhythmia	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Cardiac ischemia	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Cardiac arrest	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Bacteremia	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Coagulation disorder / Disseminated Intravascular Coagulation	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Anaemia *If yes, specify: ☐Mild ☐Moderate ☐Severe*	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Rhabdomyolysis / Myositis	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Acute renal injury/ Acute renal failure	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Gastrointestinal haemorrhage	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Pancreatitis	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Liver dysfunction	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Hyperglycemia	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Hypoglycemia	O YES O NO O UNK O N/A	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Other: _____	O YES O NO O UNK 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, If Yes fill in Section Steroids'
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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Steroid medications: ***While hospitalised or at discharge, were any of the following administered:***

Topical steroids(including eye/ear drops): O YES O NO Inhalational/Nebulized Steroids: O YES O NO

Systemic Steroids (Oral/IV/IM) O YES O NO
If YES,enter ALL systemic steroids administered at any time

Dexamethasone O YES O NO
Route: O Intravenous O Intramuscular O Oral
Dose: O <1mg/1mg O 2mg O 4mg O 6mg O 12mg O OTHER (Specify):
Frequency: O 6 Hourly O 8 Hourly O 12 Hourly O Once daily O OTHER (Specify):
Date of first dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date of last dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Hydrocortisone O YES O NO
Route: O Intravenous O Intramuscular O Oral
Dose: O 50mg O 100mg O 150mg O 200mg O OTHER (Specify):
Frequency: O 6 Hourly O 8 Hourly O 12 Hourly O Once daily O OTHER (Specify):
Date of first dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date of last dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Prednisone/Prednisolone O YES O NO
Route: O Intravenous O Intramuscular O Oral
Dose: O 20mg O 30mg O 40mg O 60mg O 80mg O OTHER (Specify):
Frequency: O 6 Hourly O 8 Hourly O 12 Hourly O Once daily O OTHER (Specify):
Date of first dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date of last dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Methylprednisolone O YES O NO
Route: O Intravenous O Intramuscular O Oral
Dose: O 4mg O 8mg O 16 mg O 32mg O 64mg O OTHER (Specify):
Frequency: O 6 Hourly O 8 Hourly O 12 Hourly O Once daily O OTHER (Specify):
Date of first dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date of last dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Other systemic steroids O YES O NO
If YES, specify other SYSTEMIC steroids
Name of steroid:
Route: O Intravenous O Intramuscular O Oral
Dose (please specify):
Frequency: O 6 Hourly O 8 Hourly O 12 Hourly O Once daily O OTHER (Specify):
Date of first dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date of last dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Immunosuppressive agents (not steroids) O YES O NO
If YES specify
Tocilizumab: O YES O NO
Dose:
Frequency: O 6 Hourly O 8 Hourly O 12 Hourly O Once daily O OTHER (Specify):
Date of first dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] Date of last dose [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Any side effects/adverse events of steroid administration: O YES O NO
Acne: O YES O NO Blurred vision: O YES O NO Insomnia: O YES O NO Skin bruising: O YES O NO
Facial swelling: O YES O NO Pedal edema: O YES O NO Stomach irritation or GI bleeding: O YES O NO Increase appetite/weight gain: O YES O NO
High Blood Sugars: (of new onset) O YES O NO High Blood Pressure (of new onset): O YES O NO
Anxiety/Depression/Suicidal thoughts: O YES O NO Inreased Infections
OTHER: O YES O NO
IF YES specify

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

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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 O Unknown
If a Study Site: Participant ID# at new facility: O Same as above O Different: [___][___][___] – [___][___][___][___] O N/A

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

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:	_____ _____ _____ _____	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

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