ISARIC DENGUE CRF

DESIGN OF THIS CASE REPORT FORM (CRF)

This CRF is set up in modules to be used for recording data on Dengue. A template for completion instructions is below. This should be tailored to the objectives of your data collection.

PRESENTATION FORM: ALWAYS complete on the first day of presentation/admission/assessment.
DAILY FORM: ALWAYS complete on the first day of presentation/admission/assessment
DAILY FORM: IF APPLICABLE, complete on the day of admission to ICU/high dependency unit/critical care (if different date to the date of first presentation/admission)
DAILY FORM: OPTION to complete on days that research specific samples are taken
DAILY FORM: OPTION to complete daily if of interest for specific analysis.
OUTCOME FORM: ALWAYS complete at discharge or death or at the end of the study period
Continue to follow-up patients who transfer between wards.

Forms	Hospital admission / initial assessment	Admission to ICU (if applicable)	Research sample taken (optional)	As per site protocol (optional)	Discharge / death / end of study
PRESENTATION FORM	COMPLETE				
DAILY FORM	COMPLETE	(COMPLETE)	(COMPLETE)	(COMPLETE)	
OUTCOME FORM					COMPLETE
FOLLOW-UP FORM				(COMPLETE)	
WITHDRAWAL FORM				(COMPLETE)	

GENERAL GUIDANCE

• Contact ISARIC Global Support Centre at data@isaric.org
• The CRF is designed to collect data obtained through examination, interview, review of hospital notes, or extraction from electronic health records. Data may be collected prospectively or retrospectively if the patient is enrolled after the date of presentation to a health facility.
• Please refer to the CRF Completion Guideline for detailed guidance on how to complete these forms.
• Your institution may capture data:
(a) on the ISARIC hosted REDCap database - contact ISARIC for access,
(b) to a REDCap database hosted at your institution - contact ISARIC if you would like support to set this up, or
(c) on a database or electronic health record system at your institution - contact ISARIC to support data mapping.
• Participant Identification Numbers consist of a 5-digit site code and a 4-digit participant number.
Please obtain a site code and register on the data management system by contacting ISARIC. Participant numbers should be assigned sequentially for each site beginning with 0001 or in blocks, possibly including alpha characters, where useful. E.g., Ward X will assign numbers from 0001 or A001 onwards and Ward Y will assign numbers from 5001 or B001 onwards.
• For participants who return for re-admission to the same site, start a new form with a different Participant Identification Number. Please check "YES-admitted previously to this facility" in the RE-ADMISSION section. Enter as 2 separate records if you are using a REDCap (or similar) database.
• For participants who transfer between two sites that are both collecting data on this form, it is preferred to have the data entered by a single site as a single admission, under the same Participant Identification Number. When this is not possible, the first site should record "Transfer to other facility" as an OUTCOME, and the second site should start a new form with a new patient number and indicate "YES-then transferred to this facility" in the RE-ADMISSION AND PREVIOUS PIN section.
• Selections with circles (○) are single selection (choose one answer only). Selections with square boxes (□) are multiple selection (choose as many answers as are applicable). Unk = Unknown

PRESENTATION

Participant Identification Number (PIN)	_____

INCLUSION CRITERIA

Suspected or confirmed infection	○ Dengue ○ Other Specify Other: _____		
Participant (or their representative) has provided consent to participate in this study.	○ Yes ○ No, participant did not agree to participate in the study ○ No, the ethics committee approved a waiver of consent ○ Unknown	If Yes: To be contacted to participate in future work, including research studies	○ Yes ○ No

ONSET & PRESENTATION

Onset date of first / earliest symptom	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		
Admitted to hospital	○ Yes ○ No ○ Unknown	If Yes:	
Date of hospital admission	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	Time of hospital admission	_____
Date of enrolment / start of data collection	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		

RE-ADMISSION AND PREVIOUS PIN

Was the patient admitted previously or transferred from any other facility during this illness episode?	○ YES-admitted previously to this facility and discharged ○ YES-admitted to other facility and discharged ○ YES-admitted to another facility, then transferred to this facility ○ No ○ Unknown	If Yes:	
Total number of previous admissions for this infection	_____	Date of earliest admission for this infection	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Has the patient's data been previously collected under a different participant identification number (PIN)?	○ Yes ○ No ○ Unknown	If Yes: Previous Participant Identification Number (PIN)	_____

DEMOGRAPHICS

Sex at birth	○ Male ○ Female ○ Other ○ Not specified/Unknown	Age	_____ ○Years ○Months ○Days	Height	_____ ○cm ○in

Weight	_____ ○kg ○lb	Race (select all that apply)	☐ Arab ☐ Black ☐ East Asian ☐ South Asian ☐ South-East Asian ☐ West Asian ☐ Latin American ☐ White ☐ Aboriginal/First Nations/Indigenous ☐ Other ☐ Unknown Specify Other: _____
Primary location of occupation	○ Home-working or unemployed ○ Indoors-office/health/education/hospitality/business/homes ○ Indoors-factory ○ Outdoors-animal contact (vet, animal farmer, abattoir worker) ○ Outdoors-agriculture/forestry/fisheries ○ Outdoors-construction/industrial/mining ○ Armed Forces ○ Student ○ Other ○ Unknown Specify Other: _____	Patient's city of residence	○ Same as health care facility ○ Different from health care facility ○ Unknown Specify Other: _____

TRAVEL HISTORY

Did the patient travel outside of their home region in the past 14 days?	○ Yes ○ No ○ Unknown

PREGNANCY

Pregnant	○ Yes ○ No ○ Unknown	If Yes: Gestational weeks assessment	_____
Post-partum (within 6 weeks of delivery)	○ Yes ○ No ○ Unknown	If Yes:	
Pregnancy outcome	○ Live birth ○ Stillbirth ○ Miscarriage ○ Termination ○ Neonatal death	Gestational weeks at pregnancy outcome	_____

CO-MORBIDITIES AND RISK FACTORS: Existing prior to this current illness and is ongoing

Chronic neurological disorder	○ Yes ○ No ○ Unknown	Dementia	○ Yes ○ No ○ Unknown	Chronic cardiac disease (not hypertension)	○ Yes ○ No ○ Unknown
Hypertension (physician diagnosed)	○ Yes ○ No ○ Unknown	Chronic pulmonary disease (not asthma)	○ Yes ○ No ○ Unknown	Asthma (physician diagnosed)	○ Yes ○ No ○ Unknown
Chronic kidney disease	○ Yes ○ No ○ Unknown				

Liver disease	○ Yes ○ No ○ Unknown			If Yes: Type of liver disease	○ Mild ○ Moderate or severe ○ Unknown
Chronic hepatitis B/C infection	○ Yes ○ No ○ Unknown				
HIV	○ Yes ○ No ○ Unknown			If Yes:	
If HIV positive: Is the patient on anti-retroviral therapy (ART)?	○ Yes ○ No ○ Unknown			If HIV positive: Most recent CD4 count (cells/uL)	○ Less than 50 ○ 50-99 ○ 100-199 ○ 200-499 ○ 500 and over ○ Unknown
Tuberculosis	○ Yes ○ No ○ Unknown	Obesity	○ Yes ○ No ○ Unknown	Asplenia	○ Yes ○ No ○ Unknown
Malignant neoplasm	○ Yes ○ No ○ Unknown	Chronic hematologic disease	○ Yes ○ No ○ Unknown	Rheumatologic disorder	○ Yes ○ No ○ Unknown
Diabetes mellitus	○ Yes ○ No ○ Unknown			If Yes:	
Type 1 diabetes mellitus	○ Yes ○ No ○ Unknown	Type 2 diabetes mellitus	○ Yes ○ No ○ Unknown	Gestational diabetes mellitus	○ Yes ○ No ○ Unknown
HbA1C result within last 6 months	_____ ○mmol/mol ○mmol/L ○%				
Malnutrition	○ Yes ○ No ○ Unknown				
Ever smoked	○ Yes ○ No ○ Unknown			If Yes:	
If yes: Current smoker	○ Yes ○ No ○ Unknown			If yes: Former smoker	○ Yes ○ No ○ Unknown
Other relevant comorbidity(s)	○ Yes ○ No ○ Unknown			Specify other relevant comorbidity(s)	_____

MEDICAL HISTORY

Is the patient known to have had previous infection(s) with this pathogen?	○ Yes ○ No ○ Unknown	If Yes: If yes: Was the patient ever hospitalised in a previous episode of the same infection?	○ Yes-admitted to hospital or ICU ○ No ○ Unknown

MEDICATION PREVIOUS 7-DAYS

Corticosteroid	○ Yes ○ No ○ Unknown	If Yes:	
Corticosteroid	○ Other	Corticosteroid administration route	○ Oral ○ Inhaled ○ IV ○ Topical ○ Unknown Specify Other: _____
Immunosuppressant agents (not corticosteroids)	○ Yes ○ No ○ Unknown	If Yes: Select Immunosuppressant agents (not corticosteroids)	○ Other Specify Other: _____
Antibiotics	○ Yes ○ No ○ Unknown	If Yes: Antibiotics	○ Azithromycin (Sumamed, Zithromax, Zmax) ○ Ceftriaxone (Rocephin, Wintriaxone) ○ Other Specify Other: _____
NSAIDs	○ Yes ○ No ○ Unknown	If Yes: NSAIDs	○ Other Specify Other: _____
Anticoagulant	○ Yes ○ No ○ Unknown	If Yes: Anticoagulant	○ Other Specify Other: _____
Intravenous fluid	○ Yes ○ No ○ Unknown		
Intravenous fluid type	○ Crystalloid ○ Albumin ○ Gelatin ○ Starches ○ Fibrinogen concentrate ○ Other fluid	If Other fluid: If other: Specify intravenous fluid type	_____
Total intravenous fluid volume in the previous 24 hours (mL) _____		Indication / reason	☐ Shock ☐ Other ☐ Unknown Specify Other: _____
Additional intravenous fluid	○ Yes ○ No ○ Unknown		
Intravenous fluid type	○ Crystalloid ○ Albumin ○ Gelatin ○ Starches ○ Fibrinogen concentrate ○ Other fluid	If Other fluid: If other: Specify intravenous fluid type	_____
Total intravenous fluid volume in the previous 24 hours (mL) _____			
Other pathogen-targeted medications	○ Yes ○ No ○ Unknown	If Yes: If yes: Specify other pathogen-targeted medications	○ Other Specify Other: _____

VACCINATION

Vaccinated for dengue	○ YES-once ○ YES-twice ○ YES-thrice ○ No ○ Unknown	If Yes:	
Date of first dengue vaccine	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	Type of first dengue vaccine	○ CYD-TVD (Dengvaxia) ○ TAK-003 (QDENGA)
Date of second dengue vaccine	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	Type of second dengue vaccine	○ CYD-TVD (Dengvaxia) ○ TAK-003 (QDENGA)
Date of third dengue vaccine	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	Type of third dengue vaccine	○ CYD-TVD (Dengvaxia) ○ TAK-003 (QDENGA)

SIGNS AND SYMPTOMS ON ADMISSION: Indicate if experienced at any time from onset of this illness to the day of presentation.

Fever / chills / rigors	○ Yes ○ No ○ Unknown	Restlessness	○ Yes ○ No ○ Unknown	Fatigue / malaise / lethargy	○ Yes ○ No ○ Unknown
Muscle aches / myalgia	○ Yes ○ No ○ Unknown	Joint pain / arthralgia	○ Yes ○ No ○ Unknown	Skin rash	○ Yes ○ No ○ Unknown
Cough	○ Yes ○ No ○ Unknown	If Yes:			
Productive	○ Yes ○ No ○ Unknown	Hemoptysis	○ Yes ○ No ○ Unknown		
Shortness of breath	○ Yes ○ No ○ Unknown	Abdominal pain	○ Yes ○ No ○ Unknown	Diarrhoea	○ Yes ○ No ○ Unknown
Vomiting	○ Yes ○ No ○ Unknown	If Yes: Persistent vomiting? (>=2/day)	○ Yes ○ No ○ Unknown		
Anorexia	○ Yes ○ No ○ Unknown				
Bleeding / haemorrhage	○ Yes ○ No ○ Unknown	If Yes:			
Severe bleeding / haemorrhage (requires intervention)	○ Yes ○ No ○ Unknown	If yes: Specify bleeding / haemorrhage site(s)	☐ Skin ☐ Petechiae ☐ Nose ☐ Gums ☐ GI tract ☐ Urinary tract ☐ Vagina ☐ Other(s) ☐ Unknown Specify Other: _____		

Headache	○ Yes ○ No ○ Unknown	Retro-orbital pain	○ Yes ○ No ○ Unknown	Seizures / convulsions	○ Yes ○ No ○ Unknown
Other sign(s) or symptom(s)	○ Yes ○ No ○ Unknown	Specify other sign(s) or symptom(s)	_____		

DAILY

DAILY DATE

DATE OF ASSESSMENT	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

ASSESSMENT

Current level of care	○ Outpatient ○ Admitted to normal ward for isolation only ○ Admitted to normal ward for clinical care ○ High dependency ○ Intensive care admission

VITAL SIGNS & ASSESSMENTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment.

Enter Vital Signs data for this date?	○ Yes ○ No		If Yes, complete the form:		
Highest temperature	_____ ○°C ○°F	HR (beats/minute)	_____	RR (bpm)	_____
Systolic BP (mmHg)	_____	Diastolic BP (mmHg)	_____	Lowest oxygen saturation SpO2 (%)	_____
Supplemental oxygen at point of SpO2 measured	○ Yes-nasal prongs ○ Yes-simple mask ○ Yes-HFNO ○ Yes-NIV ○ Yes-IMV / ECMO ○ No (Room air) ○ Unknown		If Yes: FiO2 at time of lowest SpO2	_____ ○Fraction, 0.21-1.0 ○%, 21-100 ○Highest L/min	
Capillary refill time >2 seconds	○ Yes ○ No ○ Unknown	ACVPU	○ Alert ○ Confusion ○ Verbal ○ Pain ○ Unresponsive	Glasgow Coma Score (GCS / 15)	_____
Urine flow rate (mL/24 hours)	_____				

SIGNS AND SYMPTOMS: Indicate if experienced between 00:00 to 24:00 on day of assessment.

Enter signs and symptoms data for this date?	○ Yes ○ No	If Yes, complete the form:
Restlessness	○ Yes ○ No ○ Unknown	
Bleeding / haemorrhage	○ Yes ○ No ○ Unknown	If Yes:

Severe bleeding / haemorrhage (requires intervention)	○ Yes ○ No ○ Unknown	If yes: Specify bleeding / haemorrhage site(s)	☐ Skin ☐ Petechiae ☐ Nose ☐ Gums ☐ GI tract ☐ Urinary tract ☐ Vagina ☐ Other(s) ☐ Unknown Specify Other: _____
Retro-orbital pain	○ Yes ○ No ○ Unknown		

TREATMENTS & INTERVENTIONS: Record all interventions given between 00:00 to 24:00 on day of assessment.

Enter Treatments & Interventions data for this date?	○ Yes ○ No	If Yes, complete the form:	
Any fluids prescribed	○ Yes ○ No ○ Unknown		
Oral rehydration	○ Yes ○ No ○ Unknown	If Yes: If yes: Oral rehydration volume (mL/24 hours)	_____
Parenteral IV fluid?	○ Yes ○ No ○ Unknown	If Yes: If yes: Select all parenteral fluid administered	☐ Crystalloid ☐ Albumin ☐ Gelatin ☐ Starches ☐ Other
Crystalloid volume (mL/24 hours)	_____	Albumin volume (mL/24 hours)	_____
Gelatin volume (mL/24 hours)	_____	Starches volume (mL/24 hours)	_____
Other fluid type	_____ Specify Other: _____		
Blood / blood products transfusion	○ Yes ○ No ○ Unknown	If Yes: If yes: Select all blood products that were administered.	☐ Platelets ☐ Cryoprecipitate ☐ Whole blood/packed RBC ☐ Frozen fresh plasma ☐ Fibrinogen concentrate
Platelets (units/24 hours)	_____	Cryoprecipitate (units/24 hours)	_____
Whole blood / packed RBC volume (units/24 hours)	_____	Frozen fresh plasma (units/24 hours)	_____
Fibrinogen concentrate (units/24 hours)	_____		

Intravenous immunoglobulin	○ Yes ○ No ○ Unknown	Plasmapheresis / plasma exchange	○ Yes ○ No ○ Unknown	Antibiotics	○ Yes ○ No ○ Unknown

Corticosteroids	○ Yes ○ No ○ Unknown		
Supplemental oxygen	○ Yes ○ No ○ Unknown	If Yes: If yes: Select all types of respiratory support the patient received (from 00:00 to 24:00) on the day of assessment	☐ Nasal prong ☐ Face mask ☐ High-flow nasal oxygen ☐ Non-invasive ventilation ☐ Invasive ventilation ☐ ECLS/ ECMO ☐ Unknown
PaO2 sample type	○ Arterial ○ Capillary ○ Venous ○ Unknown ○ Not done	If Not done:	
PaO2	_____ ○kPa ○mmHg	FiO2 at time of PaO2	_____ ○Fraction, 0.21-1.0 ○%, 21-100
Type of non-invasive respiratory support	○ CPAP ○ BIPAP ○ Other ○ Unknown	If Other: If other: Specify other type of non-invasive ventilation	_____
Type of ECLS / ECMO	○ Veno-venous (VV) ○ Veno-arterial (VA) ○ Unknown		
Other intervention(s) or procedure(s)	○ Yes ○ No ○ Unknown Specify Other: _____		

CRITICAL CARE INTERVENTIONS: Record all critical care interventions given between 00:00 to 24:00 on day of assessment.

Were critical care interventions administered on this date?	○ Yes ○ No ○ Unknown		If Yes, complete the form:		
ICU / ITU / HDU / Intermediate Care Unit admission	○ Yes ○ No ○ Unknown	Neuromuscular blocking agents	○ Yes ○ No ○ Unknown	Inhaled nitric oxide	○ Yes ○ No ○ Unknown
Renal replacement therapy (RRT) or dialysis / hemofiltration	○ Yes ○ No ○ Unknown		If Yes: If yes: Type of renal replacement therapy (RRT) or dialysis / hemofiltration		○ Intermittent ○ Continuous
Any vasopressor / inotropic support	○ Yes ○ No ○ Unknown		If Yes:		
If yes to any vasopressor / inotropic support: Dopamine < 5ug/kg/min OR dobutamine OR milrinone OR levosimendan		○ Yes ○ No ○ Unknown	If yes to any vasopressor / inotropic support: Dopamine 5-15ug/kg/min OR epinephrine(adrenaline) / norepinephrine(noradrenaline) < 0.1ug/kg/min OR vasopressin OR phenylephrine		○ Yes ○ No ○ Unknown

If yes to any vasopressor / inotropic support: Dopamine >15ug/kg/min OR epinephrine(adrenaline) / norepinephrine(noradrenaline) > 0.1ug/kg/min	○ Yes ○ No ○ Unknown

LABORATORY RESULTS: Record the value furthest from normal range between 00:00 to 24:00 on day of assessment.

Enter Laboratory Results data for this date?	○ Yes ○ No	If Yes, complete the form:			
Haemoglobin	_____ ○g/dL ○g/L	WBC count (10^9/L)	_____	Neutrophils	_____ ○10^9/L ○%
Lymphocytes	_____ ○10^9/L ○%	Haematocrit	_____ ○% ○L/L	Platelets	_____ ○10^9/L ○10^6/L ○10^3/uL
Prothrombin Time / PT (sec)	_____			Activated Partial Thromboplastin Time / APTT (sec)	_____
APTR	_____	INR	_____	Fibrinogen	_____ ○g/L ○mg/dL
D-Dimer	_____ ○mg/L ○ug/L	Total bilirubin	_____ ○umol/L ○mg/dL	ALT / SGPT (U/L)	_____
AST / SGOT (U/L)	_____			Gamma Glutamyl Transferase/GGT (U/L)	_____
Albumin	_____ ○g/L ○mmol/L	Random blood glucose	_____ ○mmol/L ○mg/dL ○g/L	Urea / BUN	_____ ○mmol/L ○mg/dL
Creatinine	_____ ○umol/L ○mg/dL	Sodium (mmol/L)	_____	Potassium (mmol/L)	_____
Creatine kinase (U/L)	_____			Lactate dehydrogenase/LDH (U/L)	_____
Procalcitonin (ng/mL)	_____	CRP (mg/L)	_____	Troponin I	_____ ○ng/L ○ng/mL
Lactate	_____ ○mmol/L ○mg/dL	PaCO2	_____ ○mmHg ○kPa	pH	_____
Bicarbonate / HCO3-	_____ ○mmol/L ○mEq/L	Base Excess (mmol/L)	_____	Ferritin	_____ ○ug/L ○ng/mL
IL-6 (pg/mL or ng/L)	_____			Protein TP	_____ ○g/dL ○g/L

IMAGING

Enter Imaging data for this date?	○ Yes ○ No	If Yes, complete the form:	
Chest X-ray performed	○ Yes ○ No ○ Unknown	If Yes: If yes to chest X-ray performed: Chest X-ray date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

If yes chest X-ray performed: Chest X-ray findings associated with this illness.	○ Normal or no acute change ○ Abnormal or acute change ○ Unknown		
New infiltrates present on X-ray	○ Yes, bilateral ○ Yes, unilateral ○ No ○ Unknown	If Yes: Infiltrates on X-ray consistent with	☐ Viral pneumonitis ☐ Bacterial pneumonia ☐ Pulmonary oedema ☐ Unknown
Pleural effusion on X-ray	○ Yes ○ No ○ Unknown	If Yes:	
If yes: Pleural effusion on X-ray details	○ Unilateral ○ Bilateral	If yes: Side(s) where pleural effusion identified	☐ Right ☐ Left
Ultrasound performed	○ Yes ○ No ○ Unknown	If Yes:	
If yes to ultrasound performed: Ultrasound date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	If yes to ultrasound performed: Ultrasound region	○ Chest only ○ Abdomen only ○ Chest and abdomen ○ Unknown
If yes to ultrasound performed: Ultrasound findings associated with this illness	○ Normal or no acute change ○ Abnormal or acute change ○ Unknown		
Ascites	○ Yes ○ No ○ Unknown	If Yes: If yes: Ascites grading	○ Small ○ Moderate ○ Severe
Consolidation	○ Yes ○ No ○ Unknown		
Pleural effusion	○ Yes ○ No ○ Unknown	If Yes:	
If yes to pleural effusion: Pleural effusion right size (cm)	_____	If yes to pleural effusion: Pleural effusion left size (cm)	_____
Pericardial effusion	○ Yes ○ No ○ Unknown	If Yes: If yes: Pericardial effusion size (cm)	_____
Liver size (cm)	_____	Gallbladder wall (mm)	_____
Other finding(s)	○ Yes ○ No ○ Unknown	If Yes: If yes: Specify other findings	_____

MEDICATION

MEDICATION: Record medications administered or prescribed from day of presentation to day of discharge / outcome (one form per medication).

Select agents administered while hospitalised or at discharge (one form per medication)	○ Analgesic ○ Antibiotic ○ Antifungal ○ Antipruritic ○ Antiviral ○ Corticosteroid ○ Topical antibiotic ○ Other Specify Other: _____

Is this medication treating the disease?	○ Yes ○ No	Antibiotic	○ Azithromycin (Sumamed, Zithromax, Zmax) ○ Ceftriaxone (Rocephin, Wintriaxone) ○ Other Specify Other: _____
Corticosteroid	○ Other	Corticosteroid route	○ Oral ○ IV ○ Inhaled ○ Unknown Specify Other: _____
Date agent started / first dose	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	Date agent ended / last dose	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Total number of days treatment given	_____		

OUTCOME

DIAGNOSIS

Hepatitis viruses	○ Lab confirmed ○ Lab negative ○ Not tested ○ Unknown	If Lab confirmed: Hepatitis type	○ A ○ B ○ C ○ D ○ E ○ Other Specify Other: _____
Dengue virus infection	○ Lab confirmed ○ Lab negative ○ Not tested and no clinical diagnosis ○ Not tested and clinically diagnosed ○ Unknown	If Lab confirmed, Lab negative:	

NS1 RDT	○ Positive ○ Negative ○ Unknown	NS1/IgM/IgG combination test (RDT) - NS1 first sample	○ Positive ○ Negative ○ Unknown	NS1/IgM/IgG combination test (RDT) - IgM first sample	○ Positive ○ Negative ○ Unknown
NS1/IgM/IgG combination test (RDT) - IgG first sample	○ Positive ○ Negative ○ Unknown		NS1 ELISA first sample	○ Positive ○ Negative ○ Unknown	
IgM/IgG ELISA first sample date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		IgM ELISA first sample	○ Positive ○ Negative ○ Unknown	
IgG ELISA first sample	○ Positive ○ Negative ○ Unknown		NS1 ELISA second sample	○ Positive ○ Negative ○ Unknown	
IgM/IgG ELISA second sample date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		IgM ELISA second sample	○ Positive ○ Negative ○ Unknown	
IgG ELISA second sample	○ Positive ○ Negative ○ Unknown				

Dengue PCR	○ Positive ○ Negative ○ Unknown	If Positive: Dengue virus type	○ DENV1 ○ DENV2 ○ DENV3 ○ DENV4
Bacterial infection	○ Lab confirmed ○ Lab negative ○ Not tested ○ Unknown	Specify other bacterial infection	_____
Other pathogen(s) detected	○ Yes ○ No ○ Unknown	Specify other pathogen(s) detected	_____

COMPLICATIONS: Experienced at any time from day of presentation to day of discharge / outcome.

Seizure	○ Yes ○ No ○ Unknown	Focal neurological signs	○ Yes ○ No ○ Unknown	Encephalitis	○ Yes ○ No ○ Unknown

Meningitis	○ Yes ○ No ○ Unknown	Cardiac arrhythmia	○ Yes ○ No ○ Unknown	Cardiac arrest	○ Yes ○ No ○ Unknown
Myocarditis	○ Yes ○ No ○ Unknown	Pericarditis	○ Yes ○ No ○ Unknown	Pleural effusion	○ Yes ○ No ○ Unknown
Acute Respiratory Distress Syndrome (ARDS)	○ Yes ○ No ○ Unknown	Ascites	○ Yes ○ No ○ Unknown	Acute hepatitis	○ Yes ○ No ○ Unknown
Severe liver disease (new onset)	○ Yes ○ No ○ Unknown			If Yes: If yes to severe liver disease (new onset): Hepatic encephalopathy (any grade)	○ Yes ○ No ○ Unknown
Severe bleeding (requiring intervention)	○ Yes ○ No ○ Unknown			If Yes: If yes: Severe bleeding site(s)	☐ Skin ☐ Petechiae ☐ Nose ☐ Gums ☐ GI tract ☐ Urinary tract ☐ Vagina ☐ Other(s) ☐ Unknown Specify Other: _____
Coagulation disorder / DIC	○ Yes ○ No ○ Unknown	Acute renal injury / acute renal failure	○ Yes ○ No ○ Unknown	Shock	○ Yes ○ No ○ Unknown
Re-shock episodes	○ Yes ○ No ○ Unknown			If Yes: Number of re-shock episodes	○ 1 ○ 2 ○ 3 ○ 4+ ○ Unknown
Sepsis	○ Yes ○ No ○ Unknown				
Other complication(s)	○ Yes ○ No ○ Unknown			Specify other complication(s)	_____

INTERVENTIONS: Record interventions given or prescribed from day of presentation to day of discharge / outcome.

Parenteral / IV fluid	○ Yes ○ No ○ Unknown	If Yes: If yes: Select all parenteral / IV fluid that were administered	☐ Crystalloid ☐ Albumin ☐ Gelatin ☐ Starches ☐ Other
Total crystalloid volume given during admission (mL)	_____	Total albumin volume given during admission (mL)	_____
Total gelatin volume given during admission (mL)	_____	Total starches volume given during admission (mL)	_____ Specify Other: _____

Total volume given during admission (mL) _____

Reason(s) for IV fluid (check all that apply)
- ☐ Shock
- ☐ High/rising haematocrit
- ☐ Anorexia
- ☐ Persistent vomiting
- ☐ Other

If other: Specify other reason for IV fluid _____

Date first IV fluid started _____

Date last IV fluid ended _____

Blood product transfusion
- ○ Yes
- ○ No
- ○ Unknown

If Yes: If yes: Select all blood product transfusion that were administered
- ☐ Platelets
- ☐ Cryoprecipitate
- ☐ Whole blood/packed RBC
- ☐ Frozen fresh plasma
- ☐ Fibrinogen concentrate

Platelets, total number of units _____

Cryoprecipitate, total number of units _____

Whole blood/packed RBC, total number of units _____

Fresh frozen plasma (FFP), total number of units _____

Fibrinogen concentrate, total number of units _____

Intravenous immunoglobulin
- ○ Yes
- ○ No
- ○ Unknown

Diuretics
- ○ Yes
- ○ No
- ○ Unknown

N-acetyl cysteine
- ○ Yes
- ○ No
- ○ Unknown

Fluid drainage
- ○ Yes
- ○ No
- ○ Unknown

If Yes: If yes: Reason for this drainage
- ○ Ascites
- ○ Pleural effusion

Plasmapheresis / plasma exchange
- ○ Yes
- ○ No
- ○ Unknown

If Yes: If yes: Days on plasma exchange support during admission _____

Any supplemental oxygen?
- ○ Yes
- ○ No
- ○ Unknown

If Yes:

If yes: Select all types of respiratory support the patient received
- ☐ Nasal prong
- ☐ Face mask
- ☐ High-flow nasal oxygen
- ☐ Non-invasive ventilation
- ☐ Invasive ventilation
- ☐ ECLS/ ECMO
- ☐ Unknown

Maximum O2 flow volume (L/min)
- ○ <2 L/min
- ○ 2-5 L/min
- ○ 6-10 L/min
- ○ 11-15 L/min
- ○ >15 L/min
- ○ Unknown

Number of calendar days the patient received any respiratory support during admission _____

Type of non-invasive ventilation
- ○ CPAP
- ○ BIPAP
- ○ Other
- ○ Unknown

Specify Other: _____

Type of ECLS / ECMO
- ○ Veno-venous (VV)
- ○ Veno-arterial (VA)
- ○ Unknown

Other intervention(s) or procedure(s)
- ○ Yes
- ○ No
- ○ Unknown

Specify Other: _____

CRITICAL CARE INTERVENTIONS: Record all critical care interventions given from day of presentation to day of discharge / outcome.

Were critical care interventions administered during admission?	○ Yes ○ No ○ Unknown				
ICU / ITU / HDU / Intermediate Care Unit admission	○ Yes ○ No ○ Unknown		If Yes:		
Date of first ICU / ITU / HDU / Intermediate Care Unit admission	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		Duration of first ICU / ITU / HDU / Intermediate Care Unit admission (days)	_____	
Was the patient admitted to ICU / ITU / HDU / Intermediate Care Unit more than once?	○ Yes ○ No ○ Unknown		If Yes:		
Date of final ICU / ITU / HDU / Intermediate Care Unit admission	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]		Duration of final ICU / ITU / HDU / Intermediate Care Unit admission (days)	_____	
Neuromuscular blocking agents	○ Yes ○ No ○ Unknown	Inhaled nitric oxide	○ Yes ○ No ○ Unknown	Tracheostomy inserted	○ Yes ○ No ○ Unknown
Renal replacement therapy (RRT) or dialysis	○ Yes ○ No ○ Unknown		If Yes: Number of calendar days on RRT or dialysis duration during admission	_____	
Inotropes / vasopressors	○ Yes ○ No ○ Unknown		If Yes: Total inotropes / vasopressor duration during admission (days)	_____	
Other critical care intervention(s) or procedure(s)	○ Yes ○ No ○ Unknown Specify Other: _____				

OUTCOME

Was the patient's main diagnosis dengue?	○ Yes ○ No ○ Unknown		If No: If no to was the patient's main diagnosis dengue: What was the main diagnosis?	_____	
If yes to was the patient's main diagnosis dengue: What was the final classification of dengue?	○ Uncomplicated dengue ○ Dengue with warning signs ○ Severe dengue		If Severe dengue:		
Dengue shock syndrome	○ Yes ○ No ○ Unknown	Severe bleeding	○ Yes ○ No ○ Unknown	Severe organ impairment	○ Yes ○ No ○ Unknown

Was there any secondary diagnosis?	○ Yes ○ No ○ Unknown Specify Other: _____	Outcome date	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
Outcome	○ Discharged alive ○ Still hospitalised ○ Transfer to other facility ○ Death ○ Palliative care ○ Discharged against medical advice ○ Alive, not admitted	If Discharged alive, Still hospitalised, Transfer to other facility:	
Ongoing health care needs relating to this admission for pathogen of interest	○ Yes ○ No ○ Unknown	Ongoing health care needs NOT related to pathogen episode	○ Yes ○ No ○ Unknown
Medically fit for discharge (pathogen resolved) but remains in hospital for other reason (e.g. awaiting alternate care, resident in long term health care or mental health facility)	○ Yes ○ No ○ Unknown		