## Global COVID-19 Clinical Platform — NOVEL CORONAVIRUS (COVID-19)

# RAPID CORE CASE REPORT FORM WITH PREGNANCY MODULE CRF-P Completion Guidance

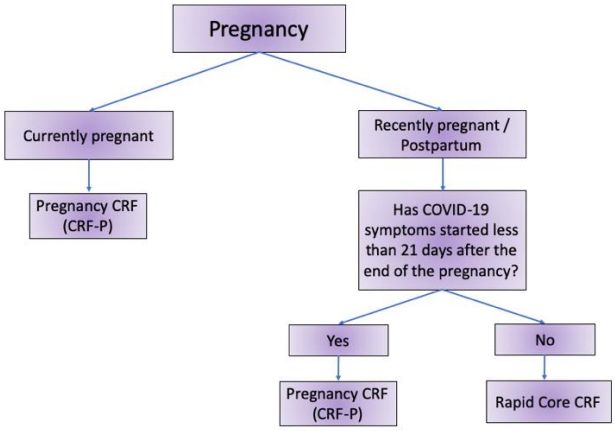
## DESIGN OF THIS CASE REPORT FORM FOR PREGNANCY (CRF-P)

This CRF-P has 3 modules:

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

**Module 2** to be completed daily during hospital stay for as many days as resources allow. Continue to follow-up women who transfer between wards.

**Module 3** to be completed at discharge or death.




## GENERAL GUIDANCE

**This CRF-P should be completed for pregnant women or recently pregnant women who delivered within 21 days from onset of symptoms.** If COVID symptoms started more than 21 days after the end of the pregnancy, please complete the Rapid Core CRF only.

- The CRF-P is designed to collect data obtained through examination, interview, and review of hospital notes. Data may be collected retrospectively if the woman is enrolled after the admission date.
- Participant identification numbers consist of a site code and a participant number. You can obtain a site code and register on the data management system by contacting COVID ClinPlatform@who.int. Participant numbers should be assigned sequentially for each site beginning with 00001. In the case of a single site recruiting participants on different wards, or where it is otherwise difficult to assign sequential numbers, it is acceptable to assign numbers in blocks or incorporating alpha characters. For example, Ward X will assign numbers from 00001 or A0001 onwards and Ward Y will assign numbers from 50001 or B0001 onwards. Enter the participant identification number at the top of every page.
- Data are entered on the central electronic WHO OpenClinica database at https://who.eclinicalhosting.com/OpenClinica/. Printed paper CRFs may be used for later transfer of the data onto the electronic database.
- In the case of a participant transferring between sites, it is preferred to maintain the same participant identification number across the sites. When this is not possible, space for recording the new number is provided.
- Complete every section. “If yes,…” questions should be left blank when they do not apply (i.e. when the answer is not yes). Leave questions that are not applicable (e.g., neonatal malformations) blank.
- Where there are multiple selection answers, choose as many as are applicable, unless stated otherwise (e.g., for maternal and neonatal outcome, only one box should be checked).
- Mark “Unknown” for any data that are not available, not applicable or unknown.
- Avoid recording data outside of the dedicated areas. Sections are available for recording additional information.
- If using paper CRFs, we recommend writing clearly in ink, using BLOCK CAPITAL LETTERS.

- Place an X when you choose the corresponding answer. To make corrections, strike through (-------) the data you wish to delete and write the correct data above it. Please initial and date all corrections.
- Please keep all the sheets for a single participant together, e.g. with a staple or participant-unique folder.
- All paper CRFs can be stored by the institution responsible for them.
- Please enter data on the electronic data capture system at https://who.eclinicalhosting.com/OpenClinica/
- Please contact us at COVID ClinPlatform@who.int to contribute data to the WHO Clinical Data Platform.

# MODULE 1. COMPLETE ON HOSPITAL ADMISSION

**Participant ID:** On each page, enter your assigned 5-digit site code followed by the 4-digit participant ID. Participant numbers should be assigned sequentially for each site beginning with 0001, 0002, 0003.

## 1a. CLINICAL INCLUSION CRITERIA

How to define a pathogen of public health interest: select “Yes” if you suspect a pathogen may: be capable of causing severe disease, be highly contagious, have outbreak potential, be an emerging pathogen, or may be of public health interest for another reason. Select “No”' if none of those apply.

Suspected or proven acute COVID-19 infection as main cause for admission. A proven COVID-19 infection refers to a laboratory-confirmed diagnosis of COVID-19. A participant may also be included if the treating clinician suspects they may have an COVID-19 infection, based on local definition. Place a cross (X) in the appropriate box (“yes”, “no”).

## 1b. DEMOGRAPHICS

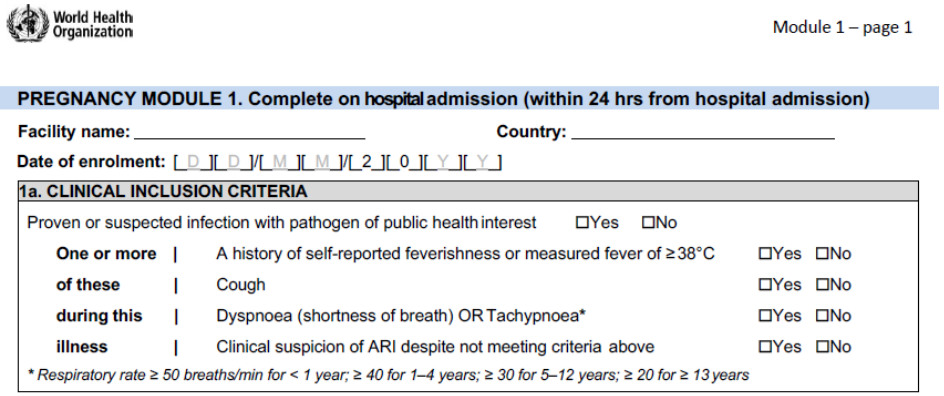
Please provide sex at birth, and date of birth in day/month/year form.

If date of birth is unknown, please record age in years, or if < 1 year old, record age in months.

Record whether the woman is a health care worker with potential exposure to infected women (for example, but not limited to: physician, nurse, nursing assistant, clinical officer, etc.).

Record whether the woman is a laboratory worker who processes or analyses human biological samples. Please select details of any pregnancy.

Pregnancy status is based on woman reported response and/or confirmatory testing if available. If there is a discrepancy, report the results of testing. Gestational weeks are based on the woman’s reported response and/or confirmatory testing (ultrasound) if available. If there is a discrepancy, report the woman's response.



World Health Organization

Module 1 – page 1

**PREGNANCY MODULE 1. Complete on hospital admission (within 24 hrs from hospital admission)**

**Facility name:** _____ **Country:** _____

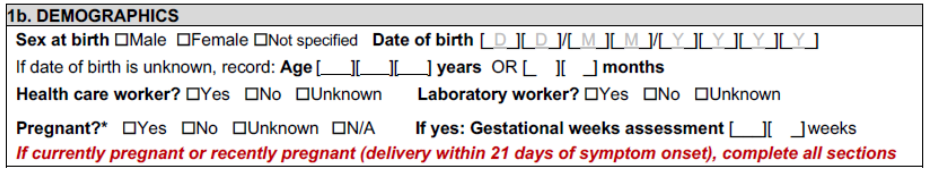
**Date of enrolment:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**1a. CLINICAL INCLUSION CRITERIA**

Proven or suspected infection with pathogen of public health interest ☐Yes ☐No

| | | | |
|---|---|---|---|
| **One or more of these during this illness** | A history of self-reported feverishness or measured fever of ≥ 38°C | ☐Yes | ☐No |
| | Cough | ☐Yes | ☐No |
| | Dyspnoea (shortness of breath) OR Tachypnoea* | ☐Yes | ☐No |
| | Clinical suspicion of ARI despite not meeting criteria above | ☐Yes | ☐No |

** Respiratory rate ≥ 50 breaths/min for < 1 year; ≥ 40 for 1–4 years; ≥ 30 for 5–12 years; ≥ 20 for ≥ 13 years*



**1b. DEMOGRAPHICS**

**Sex at birth** ☐Male ☐Female ☐Not specified **Date of birth** [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_][_Y_][_Y_]

If date of birth is unknown, record: **Age** [___][___][___] **years** OR [_ ][ _] **months**

**Health care worker?** ☐Yes ☐No ☐Unknown **Laboratory worker?** ☐Yes ☐No ☐Unknown

**Pregnant?*** ☐Yes ☐No ☐Unknown ☐N/A **If yes: Gestational weeks assessment** [___][ _]weeks

***If currently pregnant or recently pregnant (delivery within 21 days of symptom onset), complete all sections***

## 1c. DATE OF ONSET AND ADMISSION VITAL SIGNS

Please ensure all measurements are provided using the units specified.

Please provide the date of the first symptom that you clinically believe was related to this episode of COVID-19 infection in day/month/year form.

Please enter the date of admission to your site in day/month/year form.

Please provide details of clinical observations made on admission. For observations not made at admission, please record the first available data after admission measured **within 24 hours of admission**.

Record the first documented woman temperature, regardless of route (oral, peripheral, etc.) in degrees Celsius.

Record the first documented woman heart rate in beats per minute.

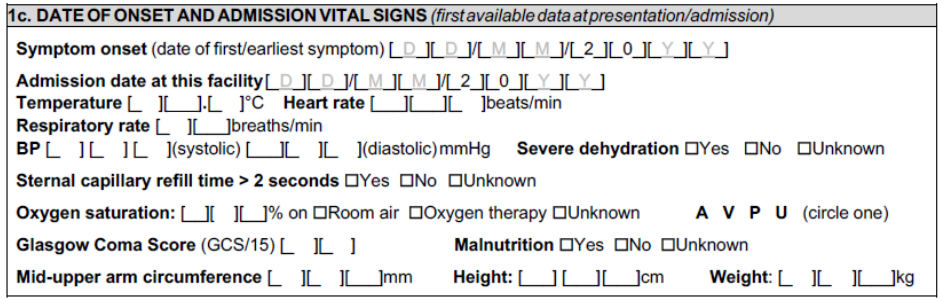
Record the first documented woman respiratory rate in breaths/min.

Record the first documented woman systolic and diastolic blood pressure measurement in mmHg.

Please record if severe dehydration was present at any point. Signs of severe dehydration include dry mucous membranes, low volumes of dark-coloured urine, sunken eyes, reduced skin elasticity.

Please record if sternal capillary refill time was > 2 seconds. This is assessed by pressing on the sternum for 5 seconds until the underlying skin turns white and then noting the time for the colour to return when the pressure is released.

Record the first documented woman **peripheral oxygen saturation** measurement as a percentage. Record whether the first documented peripheral oxygen saturation measurement occurred while the woman was breathing room air or any form of supplemental oxygen. Record “Unknown” if it is unclear whether the woman was breathing room air or oxygen at the time of the measurement. Sometimes a low measurement is obtained by pulse oximetry due to poor peripheral perfusion, and a warmer body site will give a greater value.



**1c. DATE OF ONSET AND ADMISSION VITAL SIGNS** *(first available data at presentation/admission)*

**Symptom onset** (date of first/earliest symptom) [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**Admission date at this facility** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
**Temperature** [_ ][___].[_ ]°C **Heart rate** [___][___][_ ]beats/min
**Respiratory rate** [_ ][___]breaths/min
**BP** [_ ] [_ ] [_ ](systolic) [___][_ ][_ ](diastolic) mmHg **Severe dehydration** ☐Yes ☐No ☐Unknown

**Sternal capillary refill time > 2 seconds** ☐Yes ☐No ☐Unknown

**Oxygen saturation:** [__][ ][__]% on ☐Room air ☐Oxygen therapy ☐Unknown **A V P U** (circle one)

**Glasgow Coma Score** (GCS/15) [_ ][_ ] **Malnutrition** ☐Yes ☐No ☐Unknown

**Mid-upper arm circumference** [_ ][_ ][___]mm **Height:** [___] [___][___]cm **Weight:** [_ ][_ ][___]kg

In these circumstances, where the pulse oximeter has given two different readings in succession, with no change to oxygen therapy, the greater measurement should be recorded. If the low measurement was accepted by the clinical team and changes to oxygen therapy were made before a repeat measurement, then the lowest reading should be stated.

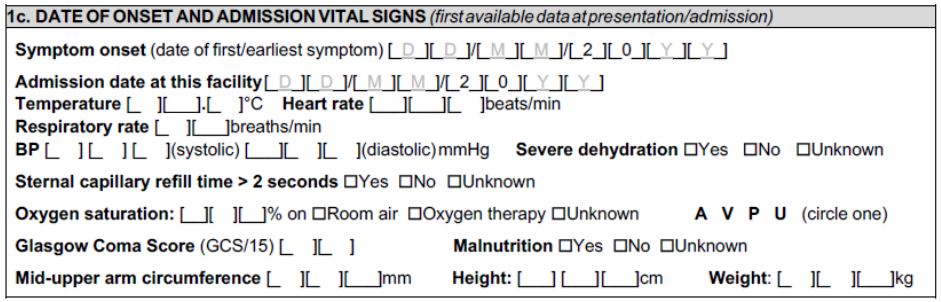
Record **AVPU.** Record the woman's first documented level of **consciousness /mental status:** woman was alert and appropriate (A); woman responds to verbal commands (V); woman responds to pressure or pain (P); woman unresponsive to any stimulus (U).

**Glasgow Coma Scale.** Record the woman's first documented level of consciousness /mental status.

Eye response (E): 1 = No opening of the eye; 2 = Eye opening in response to pain, such as squeezing the person's fingernail; 3 = Eye opening to speech; 4 = Eyes opening spontaneously.

Verbal response (V): 1 = No verbal response; 2 = Incomprehensible sounds, for example, moaning but no words; 3 = Inappropriate words such as random or exclamatory speech, nonsensical words; 4 = Confused, as in responds to questions but with some disorientation and confusion; 5 = Oriented, as in the person responds coherently and appropriately to questions.

Motor response (M): 1 = No motor response; 2 = Decerebrate posturing accentuated by pain (extensor response: adduction of arm, internal rotation of shoulder, pronation of forearm and extension at elbow, flexion of wrist and fingers, leg extension, plantarflexion of foot); 3 = Decorticate posturing accentuated by pain (flexor response: internal rotation of shoulder, flexion of forearm and wrist with clenched fist, leg extension, plantarflexion of foot); 4 = Withdrawal from pain (absence of abnormal posturing; unable to lift hand past chin with supraorbital pain but does pull away when nailbed is pinched); 5 = Localizes to pain (purposeful movements towards painful stimuli, e.g. brings hand up beyond chin when supraorbital pressure applied); 6 = Obeys commands (the person does simple things as asked).



**1c. DATE OF ONSET AND ADMISSION VITAL SIGNS** *(first available data at presentation/admission)*

**Symptom onset** (date of first/earliest symptom) [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**Admission date at this facility** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
**Temperature** [_ ][___].[_ ]°C **Heart rate** [___][___][_ ]beats/min
**Respiratory rate** [_ ][___]breaths/min
**BP** [_ ] [_ ] [_ ](systolic) [___][_ ][_ ](diastolic) mmHg **Severe dehydration** ☐Yes ☐No ☐Unknown

**Sternal capillary refill time > 2 seconds** ☐Yes ☐No ☐Unknown

**Oxygen saturation:** [__][ ][__]% on ☐Room air ☐Oxygen therapy ☐Unknown **A V P U** (circle one)

**Glasgow Coma Score** (GCS/15) [_ ][_ ] **Malnutrition** ☐Yes ☐No ☐Unknown

**Mid-upper arm circumference** [_ ][_ ][___]mm **Height:** [___] [___][___]cm **Weight:** [_ ][_ ][___]kg

Record whether any type of malnutrition (e.g. wasting, stunting, kwashiorkor, marasmus, severe acute malnutrition) is listed as a comorbidity or diagnosis.

**Mid-upper arm circumference.** Record the mid-upper arm circumference in millimetres (mm).

**Height**. Record the height in centimetres (cm).

**Weight.** Record the weight in kilograms (kg).

**1c. DATE OF ONSET AND ADMISSION VITAL SIGNS** *(first available data at presentation/admission)*

**Symptom onset** (date of first/earliest symptom) [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**Admission date at this facility** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]
**Temperature** [_ ][___].[_ ]°C **Heart rate** [___][___][_ ]beats/min
**Respiratory rate** [_ ][___]breaths/min
**BP** [_ ] [_ ] [_ ](systolic) [___][_ ][_ ](diastolic) mmHg **Severe dehydration** ☐Yes ☐No ☐Unknown

**Sternal capillary refill time > 2 seconds** ☐Yes ☐No ☐Unknown

**Oxygen saturation:** [__][ ][__]% on ☐Room air ☐Oxygen therapy ☐Unknown **A V P U** (circle one)

**Glasgow Coma Score** (GCS/15) [_ ][_ ] **Malnutrition** ☐Yes ☐No ☐Unknown

**Mid-upper arm circumference** [_ ][_ ][___]mm **Height:** [___] [___][___]cm **Weight:** [_ ][_ ][___]kg

## 1d. CO-MORBIDITIES

Please record if any of these comorbidities existed *at admission*. Where example conditions are given, these are not intended to be exhaustive and other conditions of equivalent severity should be included.

**Chronic cardiac disease (not hypertension).** Please include any:

- Coronary artery disease (angina, ischaemic heart disease, atherosclerotic heart disease, previous coronary artery bypass graft, previous cardiac stenting/coronary intervention)
- Congestive heart failure
- Congenital heart disease (that causes symptoms, requires medication or has required surgery)
- Cardiomyopathy
- Rheumatic heart disease

**Hypertension.** High blood pressure for which medication has been prescribed.

**Chronic pulmonary disease.** Please include any of:

- Chronic obstructive pulmonary disease (also chronic obstructive airways disease, chronic bronchitis, emphysema)
- Cystic fibrosis
- Bronchiectasis
- Interstitial lung disease (e.g. pulmonary fibrosis, asbestosis, autoimmune)
- A pre-existing requirement for long-term oxygen therapy.

**Asthma.** Please include clinician-diagnosed asthma (including women with diagnosed asthma not currently taking any treatment for it).

**Chronic kidney disease.** Clinician-diagnosed chronic kidney disease, including any with**:**

- Markers of kidney damage (albuminuria, haematuria of renal origin, electrolyte abnormalities due to tubular disorders, renal histological abnormalities, structural abnormalities detected by imaging)

**1d. CO-MORBIDITIES** *(existing at admission) (Unk = Unknown)*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Chronic cardiac disease** *(not hypertension)* | ☐Yes | ☐No | ☐Unk | **Diabetes** | ☐Yes | ☐No | ☐Unk |
| **Hypertension** | ☐Yes | ☐No | ☐Unk | **Current smoking** | ☐Yes | ☐No | ☐Unk |
| **Chronic pulmonary disease** | ☐Yes | ☐No | ☐Unk | **Tuberculosis** | ☐Yes | ☐No | ☐Unk |
| **Asthma** | ☐Yes | ☐No | ☐Unk | **Asplenia** | ☐Yes | ☐No | ☐Unk |
| **Chronic kidney disease** | ☐Yes | ☐No | ☐Unk | **Malignant neoplasm** | ☐Yes | ☐No | ☐Unk |
| **Chronic liver disease** | ☐Yes | ☐No | ☐Unk | **Other** | ☐Yes | ☐No | ☐Unk |
| **Chronic neurological disorder** | ☐Yes | ☐No | ☐Unk | **If yes, specify:** | | | |
| **HIV** | ☐Yes (on ART) | | ☐Yes (not on ART) | ☐No | ☐Unknown | ART regimen_____ | |

- Estimated glomerular filtration rate < 60 mL/min/1.73 $m^2$
- History of kidney transplantation.

**Chronic neurological disorder.** Please include any of:

- Cerebral palsy
- Multiple sclerosis
- Motor neurone disease
- Muscular dystrophy
- Myasthenia gravis
- Parkinson's disease
- Stroke
- Severe learning difficulty.

**HIV.** History of laboratory-confirmed HIV infection or AIDS-defining illness. Please include regardless of current viral load or CD4+ count. Please state whether the woman is currently taking antiretroviral treatment.

**Diabetes.** Record "Yes" if the woman has a current diagnosis of or is being treated for type I or type II diabetes mellitus requiring oral or subcutaneous treatment.

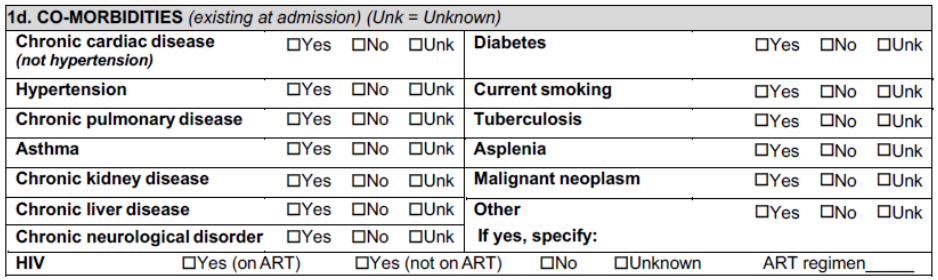
**Current smoking.** Smoking at least one cigarette, cigar, pipe or equivalent per day before the onset of the current illness. Do not include smoke-free tobacco products such as chewed tobacco or electronic nicotine delivery devices.

**Tuberculosis.** Women currently receiving treatment for tuberculosis. Latent tuberculosis should not be included here. Women who have been cured of tuberculosis should not be included here. Those who have chronic pulmonary sequelae following their tuberculosis should be included as chronic pulmonary disease.

**Asplenia.** Please include all who have had a splenectomy, women with a non-functional spleen secondary to sickle-cell disease, and congenital asplenia.

**Malignant neoplasm.** Current solid organ or haematological malignancy. Please do not include malignancies that have been declared "cured" ≥ 5 years ago with no evidence of ongoing disease. Do not include non-melanoma skin cancers. Do not include benign growths or dysplasia.

**Other.** Please include other comorbidities that the clinical team feels may affect the woman's physiological reserves or response to this disease or treatment. Include here any co-existing infectious diseases. Please specify these other comorbidities.



| 1d. CO-MORBIDITIES *(existing at admission) (Unk = Unknown)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Chronic cardiac disease** ***(not hypertension)*** | ☐Yes | ☐No | ☐Unk | **Diabetes** | ☐Yes | ☐No | ☐Unk |
| **Hypertension** | ☐Yes | ☐No | ☐Unk | **Current smoking** | ☐Yes | ☐No | ☐Unk |
| **Chronic pulmonary disease** | ☐Yes | ☐No | ☐Unk | **Tuberculosis** | ☐Yes | ☐No | ☐Unk |
| **Asthma** | ☐Yes | ☐No | ☐Unk | **Asplenia** | ☐Yes | ☐No | ☐Unk |
| **Chronic kidney disease** | ☐Yes | ☐No | ☐Unk | **Malignant neoplasm** | ☐Yes | ☐No | ☐Unk |
| **Chronic liver disease** | ☐Yes | ☐No | ☐Unk | **Other** | ☐Yes | ☐No | ☐Unk |
| **Chronic neurological disorder** | ☐Yes | ☐No | ☐Unk | **If yes, specify:** | | | |
| **HIV** ☐Yes (on ART) ☐Yes (not on ART) ☐No ☐Unknown ART regimen_____ | | | | | | | |

## 1e. PRE-ADMISSION AND CHRONIC MEDICATION

Please state whether any of these medications were taken in the 14 days before admission.

Record “Yes” if woman reports taking any ACE inhibitor (e.g. captopril, lisinopril, etc.) in the 14 days prior to admission.

Record “Yes” if woman reports taking any angiotensin II receptor blockers (ARB) (e.g. losartan, valsartan) in the 14 days prior to admission.

For non-steroidal anti-inflammatory (NSAID) do not include low-dose aspirin taken for cardioprotective purposes. Record “Yes” if woman reports taking any NSAID (e.g. ibuprofen, ketorolac, naproxen, etc.) in the 14 days prior to admission.

**1e. PRE-ADMISSION AND CHRONIC MEDICATION Were any of the following taken within 14 days of admission:**

| | |
|---|---|
| **Angiotensin converting enzyme inhibitors (ACE inhibitors)?** | ☐Yes ☐No ☐Unknown |
| **Angiotensin II receptor blockers (ARBs)?** | ☐Yes ☐No ☐Unknown |
| **Non-steroidal anti-inflammatory (NSAID)?** | ☐Yes ☐No ☐Unknown |
| **Antiviral?** ☐ Chloroquine/hydroxychloroquine ☐ Azithromycin ☐ Lopinavir/Ritonavir ☐ Other:_____ | |

## 1f. SIGNS AND SYMPTOMS ON ADMISSION

Please report any of the signs and symptoms reported by the woman or observed on physical exam at admission. Indicate “Unknown” also if not recorded or not available.

**1f. SIGNS AND SYMPTOMS Reported/assessed on the day of ADMISSION** *(Unk = Unknown)*

| | | | |
|---|---|---|---|
| **History of fever** | ☐Yes ☐No ☐Unk | **Lower chest wall** | ☐Yes ☐No ☐Unk |
| **Cough** | ☐Yes ☐No ☐Unk | **Headache** | ☐Yes ☐No ☐Unk |
| **with sputum production** | ☐Yes ☐No ☐Unk | **Altered consciousness/confusion** | ☐Yes ☐No ☐Unk |
| **with haemoptysis** | ☐Yes ☐No ☐Unk | **Seizures** | ☐Yes ☐No ☐Unk |
| **Sore throat** | ☐Yes ☐No ☐Unk | **Abdominal pain** | ☐Yes ☐No ☐Unk |
| **Runny nose** | ☐Yes ☐No ☐Unk | **Vomiting/nausea** | ☐Yes ☐No ☐Unk |
| **Wheezing** | ☐Yes ☐No ☐Unk | **Diarrhoea** | ☐Yes ☐No ☐Unk |
| **Chest pain** | ☐Yes ☐No ☐Unk | **Conjunctivitis** | ☐Yes ☐No ☐Unk |
| **Muscle aches** | ☐Yes ☐No ☐Unk | **Skin rash** | ☐Yes ☐No ☐Unk |
| **Joint pain** | ☐Yes ☐No ☐Unk | **Skin ulcers** | ☐Yes ☐No ☐Unk |
| **Fatigue/malaise** | ☐Yes ☐No ☐Unk | **Lymphadenopathy** | ☐Yes ☐No ☐Unk |
| **Loss of taste** | ☐Yes ☐No ☐Unk | **Inability to walk** | ☐Yes ☐No ☐Unk |
| **Loss of smell** | ☐Yes ☐No ☐Unk | **Bleeding** | ☐Yes ☐No ☐Unk |
| **Shortness of breath** | ☐Yes ☐No ☐Unk | **If bleeding, specify site(s):** | |
| **Stroke: ischaemic stroke** | ☐Yes ☐No ☐Unk | | |
| **Stroke: intracerebral haemorrhage** | ☐Yes ☐No ☐Unk | | |
| **Other** | ☐Yes ☐No ☐Unk | | |
| If yes, specify: _____ | | | |

## 1g. MEDICATION

Please record if the woman was already taking any of these medications at the time of admission or record all treatments received on the day of admission. For women admitted late in the evening or at night, please include medications up to and including those started the first time the woman was reviewed by the most senior clinician responsible for their care (e.g. consultant or attending).

**Oral/orogastric fluids.** Include any fluids delivered clinically but not if woman was drinking fluids normally.

**Intravenous fluids.** Record "Yes" if on the calendar day of admission, the woman received intravenous fluids for rehydration, maintenance requirements or resuscitation.

**Antiviral.** Record "Yes" if on the calendar day of admission, the woman received an antiviral. Please indicate which drug was taken among those listed. Specify other drug (e.g. remdesivir, etc.) in the free text field.

**Corticosteroid.** Record "Yes" if on the calendar day of admission, the woman received a corticosteroid (e.g. hydrocortisone, decadron, prednisone, beclomethasone, budesonide, etc.). Select all applicable routes of administration; record the maximum daily dose. Leave blank if it does not apply.

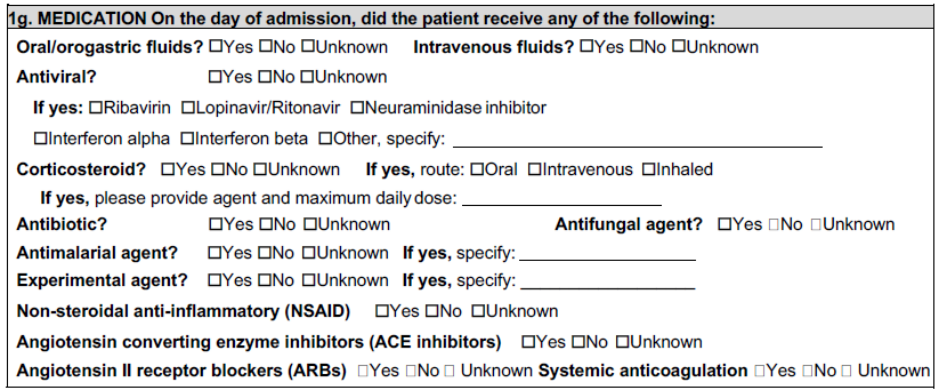
**Antibiotic.** Record "Yes" if on the calendar day of admission, the woman received an antibiotic (e.g. levofloxacin, meropenem, ceftriaxone, vancomycin, etc.).

**Antifungal.** Record "Yes" if on the calendar day of admission, the woman received an antifungal (e.g. amphotericin, fluconazole).

**Antimalarial agent.** Record "Yes" if on the calendar day of admission, the woman received an antimalarial (e.g. artemisinin-based combination therapies, hydroxychloroquine, chloroquine, artesunate, sulfadoxine-pyrimethamine, etc.).

**Experimental agent.** Record "Yes" if on the calendar day of admission, the woman received an experimental agent for treatment not listed above as an antiviral (e.g. azithromycin, hydroxychloroquine, IVIg, immunomodulators, etc.).

**Non-steroidal anti-inflammatory (NSAID).** Record "Yes" if on the calendar day of admission, the woman received an NSAID (e.g. ibuprofen, ketorolac, naproxen, etc.). Do not include



**1g. MEDICATION On the day of admission, did the patient receive any of the following:**

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

**Antiviral?** ☐Yes ☐No ☐Unknown

**If yes:** ☐Ribavirin ☐Lopinavir/Ritonavir ☐Neuraminidase inhibitor

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

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

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

**Antibiotic?** ☐Yes ☐No ☐Unknown **Antifungal agent?** ☐Yes ☐No ☐Unknown

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

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

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

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

**Angiotensin II receptor blockers (ARBs)** ☐Yes ☐No ☐ Unknown **Systemic anticoagulation** ☐Yes ☐No ☐ Unknown

low-dose aspirin taken for cardioprotective purposes.

**Angiotensin converting enzyme inhibitors (ACE inhibitors).** Record "Yes" if the woman reports taking any ACE inhibitor (e.g. captopril, lisinopril, etc.).

**Angiotensin II receptor blockers (ARBs).** Record "Yes" if the woman reports taking any ARB (e.g. losartan, valsartan) in the 14 days prior to admission.

**Systemic anticoagulation.** Record "Yes" if on the calendar day of admission, the woman received systemic anticoagulation (e.g. heparin in any formulation, warfarin, etc.).

## 1h. SUPPORTIVE CARE

Please record all treatments received on the day of admission. For women admitted late in the evening or at night, please include medications up to and including those started the first time the woman was reviewed by the most senior clinician responsible for their care (e.g. consultant or attending).

**ICU.** Record "Yes" if on the calendar day of admission, the woman was admitted to the intensive care or high dependency unit on the day of admission.

**Oxygen therapy.** Please provide details of any supplemental oxygen therapy given. Record "Yes" if on the calendar day of admission, the woman received oxygen therapy (e.g. low-flow, high-flow, face mask). If the woman received oxygen therapy, record the highest flow administered on the calendar of admission. Leave blank if it does not apply. If the woman received oxygen therapy, record the source of oxygen. If multiple sources used, select the most common source. Leave blank if it does not apply. If the woman received oxygen therapy, record which interface was used. If multiple interfaces used, select the primary interface used. Leave blank if it does not apply.

**Non-invasive ventilation.** Record "Yes" if on the calendar day of admission, the woman received non-invasive ventilation. Please include any positive-pressure treatment given via a tight-fitted mask. This can be a continuous positive pressure (CPAP) or a pressure that changes with the breathing cycle (BIPAP).

**Invasive ventilation.** Record "Yes" if on the calendar day of admission, the woman received invasive ventilation (e.g. mechanical ventilation with a ventilator). Do not

**1h. SUPPORTIVE CARE On the day of admission, did the patient receive any of the following:**

**ICU or high dependency unit admission?** ☐Yes ☐No ☐Unknown

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

**$O_2$ flow:** ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ > 15 L/min ☐ Unknown

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

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

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

**Invasive ventilation (any)?** ☐Yes ☐No ☐Unknown **If yes, what were the following values closest to 08:00:**
PEEP (cm $H_2O$) _____; $FiO_2$ (%) _____; Plateau pressure (cm $H_2O$) _____; $PaCO_2$ _____; $PaO_2$_____

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

**Prone position?** ☐Yes ☐No ☐Unknown

**Inotropes/vasopressors?** ☐Yes ☐No ☐Unknown

**1h. SUPPORTIVE CARE On the day of admission, did the patient receive any of the following:**

**ICU or high dependency unit admission?** ☐Yes ☐No ☐Unknown

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

**$O_2$ flow:** ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ > 15 L/min ☐ Unknown

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

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

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

**Invasive ventilation (any)?** ☐Yes ☐No ☐Unknown **If yes, what were the following values closest to 08:00:**
PEEP (cm $H_2O$) _____; $FiO_2$ (%) _____; Plateau pressure (cm $H_2O$) _____; $PaCO_2$ _____; $PaO_2$_____

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

**Prone position?** ☐Yes ☐No ☐Unknown

**Inotropes/vasopressors?** ☐Yes ☐No ☐Unknown

include women who are breathing independently via a tracheostomy.

**PEEP.** If on the calendar day of admission, the woman received ventilation, record the positive end-expiratory pressure (PEEP) ($cmH_2O$) measured closest to 08:00.

**$FiO_2$.** If on the calendar day of admission, the woman received invasive ventilation, record the fraction of inspired oxygen ($FiO_2$) (%) measured closest to 08:00. If on the calendar day of admission, the woman received invasive ventilation, record the plateau pressure ($cmH_2O$) measured closest to 08:00.

**$PaCO_2$.** If on the calendar day of admission, the woman received invasive ventilation and had an arterial blood gas drawn, record the arterial partial pressure of carbon dioxide ($PaCO_2$) recorded closest to 08:00.

**$PaO_2$.** If on the calendar day of admission, the woman received invasive ventilation and had an *arterial* blood gas drawn, record the arterial partial pressure of oxygen ($PaO_2$) recorded closest to 08:00.

**Extracorporeal support.** Record "Yes" if on the calendar day of admission, the woman received extracorporeal support (e.g. ECMO, ECLS, E-CPR).

**Prone position.** Please record for any ventilated women if they have been in the prone position to aid their ventilation.

**Inotropes/vasopressors.** Record "Yes" if on the calendar day of admission, the woman received inotropes/vasopressors as a continuous infusion (e.g. epinephrine/ adrenaline, norepinephrine, vasopressin, etc.).

## 1i. LABORATORY RESULTS ON ADMISSION

Please include results in the first 24 hours following admission. For tests that were repeated for clinical reasons, please include the first measurement. Please specify the units utilized for each measurement.

**1h. SUPPORTIVE CARE On the day of admission, did the patient receive any of the following:**

**ICU or high dependency unit admission?** ☐Yes ☐No ☐Unknown

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

**$O_2$ flow:** ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ > 15 L/min ☐ Unknown

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

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

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

**Invasive ventilation (any)?** ☐Yes ☐No ☐Unknown **If yes, what were the following values closest to 08:00:**
PEEP (cm $H_2O$) _____; $FiO_2$ (%) _____; Plateau pressure (cm $H_2O$) _____; $PaCO_2$ _____; $PaO_2$_____

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

**Prone position?** ☐Yes ☐No ☐Unknown

**Inotropes/vasopressors?** ☐Yes ☐No ☐Unknown

**1i. LABORATORY RESULTS ON ADMISSION** *(*record units if different from those listed)*

| Parameter | Value* | Units | | | Parameter | Value* | Units | |
|---|---|---|---|---|---|---|---|---|
| Haemoglobin | | ☐ g/L | ☐ g/dL | | Creatinine | | ☐ mg/L | ☐ µmol/L |
| WBC count | | ☐ /mm³ | ☐ G/L (= x10⁹/L) | | Sodium | | ☐ mEq/L = mmol/L | |
| Haematocrit | | ☐ % | | | Potassium | | ☐ mEq/L = mmol/L | |
| Platelets | | ☐ /mm³ | ☐ G/L (= x10⁹/L) | | Procalcitonin | | ☐ ng/mL | ☐ µg/L |
| APTT/APTR | | ☐ seconds | | | CRP | | ☐ mg/L | |
| PT (seconds) | | ☐ seconds | | | LDH | | ☐ IU/L | |
| INR | | | | | Creatine kinase | | = ☐ = IU/L | ☐ UKAT/L |
| ALT/SGPT | | ☐ IU/L | | | Troponin | | ☐ ng/mL | ☐ µg/L |
| AST/SGOT | | ☐ IU/L | | | ESR | | ☐ mm/hour | |
| Total bilirubin | | ☐ mg/L | ☐ µmol/L | | D-dimer | | ☐ ng/mL | ☐ µg/L |
| Urea (BUN) | | ☐ g/L | ☐ mg/dL | ☐ mmol/L | Ferritin | | ☐ ng/mL | ☐ µg/L |
| Lactate | | ☐ mg/dL | ☐ mmol/L | | IL-6 | | ☐ pg/mL | |

## 1j. PREGNANCY STATUS ON ADMISSION

Please include whether woman was pregnant but not in labour, pregnant and in labour, postpartum, or post-abortion/miscarriage. Please also indicate if the woman is breastfeeding upon admission or not.

**Postpartum.** Record number of days postpartum. This number will have to be ≤21. If the woman is over 21 days postpartum, then do not continue completing this form and use the Rapid Core CRF.

**Number of foetuses.** Record number of foetuses in current pregnancy or most recently ended pregnancy (for women admitted at postpartum or post-abortion).

**Gestational age.** Gestational weeks are based on the woman's reported response and/or confirmatory testing (ultrasound) if available. If there is a discrepancy, report the woman's response.

| 1j. PREGNANCY STATUS UPON ADMISSION | |
|---|---|
| Pregnant not in labour | ☐ |
| Pregnant in labour | ☐ |
| Postpartum [days]* | ☐ [days] Breastfeeding? ☐Yes ☐No |
| Post-abortion/miscarriage | ☐ |
| Number of foetuses | ☐Singleton ☐Twin ☐Triplet ☐Other [number] ☐Unknown |
| Best estimate of gestational age in completed weeks | [_W_][_W_] weeks |

## 1k. ABORTION OR MISCARRIAGE PRIOR TO AD MISSION

If the woman had an abortion or a miscarriage prior to being admitted to the health centre, please indicate the date as reported by the woman.

Record whether the woman had any COVID-19 symptoms when the abortion or miscarriage occurred as reported by the woman.

| 1k. ABORTION OR MISCARRIAGE *(prior to admission)* | |
|---|---|
| Date of induced abortion or spontaneous abortion/miscarriage? | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] |
| Were symptoms of COVID-19 disease present at the time? | ☐Yes ☐No ☐Unknown |

## 1l. OBSTETRIC HISTORY UPON ADMISSION

Record number of previous pregnancies of at least 22 weeks gestation, number of previous vaginal deliveries, and number of previous Caesarean deliveries, as reported by the woman.

| 1l. OBSTETRIC HISTORY |
|---|
| Number of previous pregnancies beyond 22 weeks gestation [number] |
| Number of previous vaginal deliveries [number] |
| Number of previous cesarean deliveries [number] |

## 1m. PREVIOUS DELIVERIES

Record yes or no for previous deliveries, if relevant. If the woman had no prior deliveries, check "No" for every item.

| 1m. Please tick any which apply to previous deliveries: | |
|---|---|
| Preterm birth (< 37 weeks' gestation) | ☐Yes ☐No ☐Unknown |
| Congenital anomaly | ☐Yes ☐No ☐Unknown |
| Stillborn | ☐Yes ☐No ☐Unknown |
| Neonatal death (0–6 days) | ☐Yes [day: ] ☐No ☐Unknown |
| Weight < 2.5 kg | ☐Yes ☐No ☐Unknown |
| Weight > 4.5 kg | ☐Yes ☐No ☐Unknown |

## 1n. RISK FACTORS DURING CURRENT OR RECENT PREGNANCY

Record yes or no or unknown for alcohol consumption and illicit/recreational drug use during the current pregnancy or recently ended pregnancy (for postpartum/post-abortion women) as reported by the woman.

| 1n. ALCOHOL, DRUGS – RISK FACTORS DURING THIS PREGNANCY | |
|---|---|
| **Alcohol consumption** | ☐Yes ☐No ☐Unknown |
| **Illicit/recreational drug use** | ☐Yes ☐No ☐Unknown |

## 1o. MEDICATIONS DURING CURRENT OR RECENT PREGNANCY

Please record if the woman was already taking any of these medications prior to onset of current illness at the time of admission.

**Fever or pain treatment.** Record "Yes" if the woman reported having received acetaminophen/paracetamol, an NSAID (e.g. ibuprofen, ketorolac, naproxen, etc.) or other medication to treat fever or pain at any time during the current or most recent pregnancy.

**Anticonvulsants.** Record "Yes" if the woman reported having received medication to prevent convulsions during the current or most recent pregnancy (e.g. carbamezapine, lamotrigine, phenobarbital, etc). Please indicate the generic name for the drug.

**Anti-nausea.** Record "Yes" if the woman reported having received medication to prevent nausea during the current or most recent pregnancy (e.g. metoclopramide, ondansetron, pyridoxine). Please indicate the generic name for the drug.

**Prenatal vitamins and micronutrients.** Record "Yes" if the woman reported having received prenatal vitamins or other micronutrients (e.g. folic acid, ferritin, calcium carbonate, etc) during the current or most recent pregnancy. Please indicate the generic name for the drug.

**Antivirals.** Record "Yes" if the woman reported having received medication to treat a viral infection during the current or most recent pregnancy (e.g. oseltamivir, zanamivir, acyclovir). Please indicate the generic name for the drug.

**Antibiotics.** Record "Yes" if the woman reported having received medication to treat a bacterial infection during the current or most recent pregnancy (e.g. penicillins, cephalosporins, clindamycin). Please indicate the generic name for the drug.

| 1o. MEDICATIONS DURING THIS PREGNANCY *(Prior to onset of current illness episode)* | | |
|---|---|---|
| **Fever or pain treatment** | **Acetaminophen/paracetamol** | ☐Yes ☐No ☐Unknown |
| | **NSAID/s** | ☐Yes ☐No ☐Unknown |
| | **Other/s (specify): [ ]** | |
| **Anticonvulsants** | ☐Yes ☐No ☐Unknown<br>**If yes, specify generic name:**<br>[ ] | |
| **Anti-nausea** | ☐Yes ☐No ☐Unknown<br>**If yes, specify generic name:**<br>[ ] | |
| **Prenatal vitamins and micronutrients** | ☐Yes ☐No ☐Unknown<br>**If yes, specify generic name:**<br>[ ] | |
| **Antivirals** | ☐Yes ☐No ☐Unknown<br>**If yes, specify generic name:**<br>[ ] | |
| **Antibiotics** | ☐Yes ☐No ☐Unknown<br>**If yes, specify generic name:**<br>[ ] | |

## 1p. SIGNS AND SYMPTOMS UPON ADMISSION

Please provide details of history or clinical observations relating to current or most recent pregnancy made on admission. For observations not made at admission, please record the first available data after admission measured **within 24 hours of admission**.

Record whether the woman had or reported any vaginal discharge or bleeding, headaches, changes in vision, abdominal pain (in right upper quadrant), decreased or no fetal movement, or uterine contractions.

| 1p. ADMISSION SIGNS AND SYMPTOMS | | | |
|---|---|---|---|
| **Vaginal watery discharge** | ☐Yes | ☐No | ☐Unknown |
| **Vaginal bleeding** | ☐Yes | ☐No | ☐Unknown |
| **Headaches** | ☐Yes | ☐No | ☐Unknown |
| **Vision changes** | ☐Yes | ☐No | ☐Unknown |
| **Right upper quadrant (abdominal) pain** | ☐Yes | ☐No | ☐Unknown |
| **Decreased or no fetal movement** | ☐Yes | ☐No | ☐Unknown |
| **Uterine contractions** | ☐Yes | ☐No | ☐Unknown |

## 1q. FETAL HEART RATE

Please provide fetal heart rate, for women currently pregnant upon admission, as beats per minute. For observations not made at admission, please record the first available data after admission measured **within 24 hours of admission**.

| 1q. FETAL HEART RATE *(first available data at presentation/admission)* | |
|---|---|
| **Fetal heart rate** | **(FHR):** [_ _][_ _][_ _] beats/min |

## MODULE 2. DAILY FOLLOW UP DURING HOSPITAL STAY

**Complete daily during hospital stay and for as many days as resources allow.**
Please state the date of follow-up for this form (using day/month/year form). All data should refer to that calendar date, from midnight to midnight.

### 2a. VITAL SIGNS

Record one value for the calendar day (midnight to midnight) for the date of follow-up stated on the form.

**Temperature.** Please state the greatest recorded temperature in degrees Celsius.

**Heart rate.** Please state the greatest recorded heart rate.

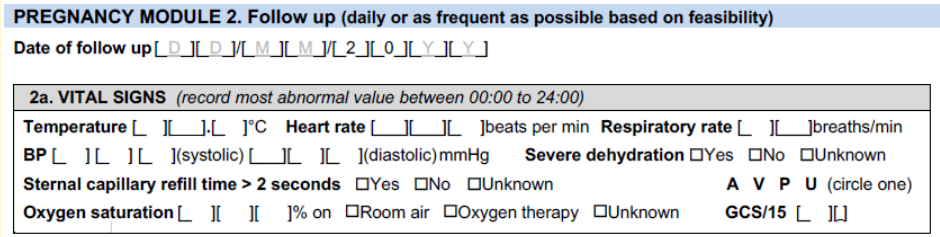
**Respiratory rate.** Please state the greatest recorded respiratory rate.

**Blood pressure.** Please state the lowest recorded blood pressure.

**Severe dehydration.** Please record if severe dehydration was present at any point during the follow-up day. Signs of severe dehydration include dry mucous membranes, low volumes of dark-coloured urine, sunken eyes, reduced skin elasticity.

**Sternal capillary refill time.** Please record if sternal capillary refill time was > 2 seconds. This is assessed by pressing on the sternum for 5 seconds until the underlying skin turns white and then noting the time for the colour to return when the pressure is released.

**Oxygen saturation.** Please state the lowest reliable oxygen saturation recorded.
Record the first documented woman peripheral oxygen saturation measurement as a percentage. Record whether the first documented woman peripheral oxygen saturation measurement occurred while the woman was breathing room air or any form of supplemental oxygen. Record “Unknown” if it is unclear whether the woman was breathing room air or oxygen at the time of the measurement. Sometimes a low measurement is obtained by pulse oximetry due to poor peripheral perfusion, and a warmer body site will give a greater value. In these circumstances, where the pulse oximeter has given two different readings in succession, with no change to oxygen therapy, the greater measurement should be recorded. If the low measurement was accepted by the clinical team and changes to oxygen therapy were made before a repeat measurement, then the lowest reading should be stated.



**PREGNANCY MODULE 2. Follow up** (daily or as frequent as possible based on feasibility)

**Date of follow up** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

**2a. VITAL SIGNS** *(record most abnormal value between 00:00 to 24:00)*

**Temperature** [_ ][___].[_ ]°C **Heart rate** [___][___][_ ]beats per min **Respiratory rate** [_ ][___]breaths/min
**BP** [_ ] [_ ] [_ ](systolic) [___][_ ][_ ](diastolic) mmHg **Severe dehydration** ☐Yes ☐No ☐Unknown
**Sternal capillary refill time > 2 seconds** ☐Yes ☐No ☐Unknown **A V P U** (circle one)
**Oxygen saturation** [_ ][ ][ ]% on ☐Room air ☐Oxygen therapy ☐Unknown **GCS/15** [_ ][_]

**AVPU.** Record the woman's first documented level of consciousness/mental status: woman was alert and appropriate (A); woman responds to verbal commands (V); woman responds to pressure or pain (P); woman unresponsive to any stimulus (U).

**Glasgow Coma Scale.** Record the woman's first documented level of consciousness/mental status.

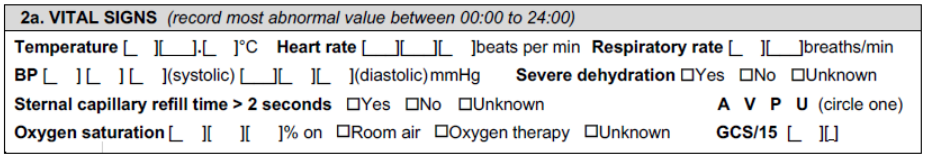
Eye response (E): 1 = No opening of the eye; 2 = Eye opening in response to pain, such as squeezing the person's fingernail; 3 = Eye opening to speech; 4 = Eyes opening spontaneously.

Verbal response (V): 1 = No verbal response; 2 = Incomprehensible sounds, for example, moaning but no words; 3 = Inappropriate words such as random or exclamatory speech, nonsensical words; 4 = Confused, as in responds to questions but with some disorientation and confusion; 5 = Oriented, as in the person responds coherently and appropriately to questions.

Motor response (M): 1 = No motor response; 2 = Decerebrate posturing accentuated by pain (extensor response: adduction of arm, internal rotation of shoulder, pronation of forearm and extension at elbow, flexion of wrist and fingers, leg extension, plantarflexion of foot); 3 = Decorticate posturing accentuated by pain (flexor response: internal rotation of shoulder, flexion of forearm and wrist with clenched fist, leg extension, plantarflexion of foot); 4 = Withdrawal from pain (absence of abnormal posturing; unable to lift hand past chin with supraorbital pain but does pull away when nailbed is pinched); 5 = Localizes to pain (purposeful movements towards painful stimuli; e.g. brings hand up beyond chin when supraorbital pressure applied); 6 = Obeys commands (the person does simple things as asked).

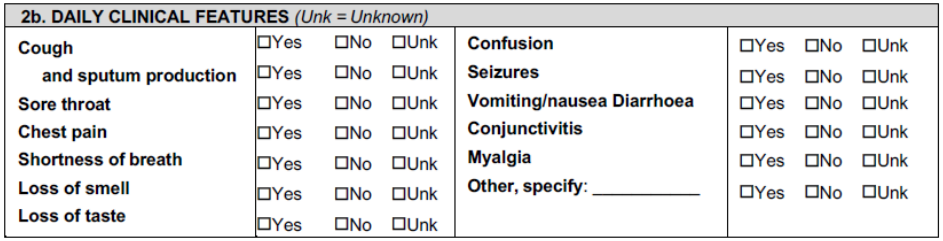
## 2b. DAILY CLINICAL FEATURES

Record “Yes” for all that were present at any time during the date of follow-up stated on the form.



**2a. VITAL SIGNS** *(record most abnormal value between 00:00 to 24:00)*

**Temperature** [_ ][___].[_ ]°C **Heart rate** [___][___][_ ]beats per min **Respiratory rate** [_ ][___]breaths/min
**BP** [_ ] [_ ] [_ ](systolic) [___][_ ][_ ](diastolic) mmHg **Severe dehydration** ☐Yes ☐No ☐Unknown
**Sternal capillary refill time > 2 seconds** ☐Yes ☐No ☐Unknown **A V P U** (circle one)
**Oxygen saturation** [_ ][ ][ ]% on ☐Room air ☐Oxygen therapy ☐Unknown **GCS/15** [_ ][_]



**2b. DAILY CLINICAL FEATURES** *(Unk = Unknown)*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Cough** | ☐Yes | ☐No | ☐Unk | **Confusion** | ☐Yes | ☐No | ☐Unk |
| **and sputum production** | ☐Yes | ☐No | ☐Unk | **Seizures** | ☐Yes | ☐No | ☐Unk |
| **Sore throat** | ☐Yes | ☐No | ☐Unk | **Vomiting/nausea Diarrhoea** | ☐Yes | ☐No | ☐Unk |
| **Chest pain** | ☐Yes | ☐No | ☐Unk | **Conjunctivitis** | ☐Yes | ☐No | ☐Unk |
| **Shortness of breath** | ☐Yes | ☐No | ☐Unk | **Myalgia** | ☐Yes | ☐No | ☐Unk |
| **Loss of smell** | ☐Yes | ☐No | ☐Unk | **Other, specify:** _____ | ☐Yes | ☐No | ☐Unk |
| **Loss of taste** | ☐Yes | ☐No | ☐Unk | | | | |

## 2c. LABORATORY RESULTS

Please state all laboratory results for the calendar day (midnight to midnight) of follow-up stated on the form. The day of follow-up for this form should correspond to the date of sample collection, not the date when the laboratory reported the result. If a test was repeated to monitor progress (e.g. following treatment for an electrolyte abnormality) please state the most abnormal result (i.e. the result furthest from the normal physiological range as stated by your laboratory). Please reports these results with the unit used in your laboratory in the value column.

**2c. LABORATORY RESULTS** *(*record units if different from those listed)*

| Parameter | Value* | Units | | | Parameter | Value* | Units | | |
|---|---|---|---|---|---|---|---|---|---|
| Haemoglobin | | __ g/L | __ g/dL | | Creatinine | | __ mg/L | __ µmol/L | |
| WBC count | | ___ /mm³ | ___ G/L (= x10⁹/L) | | Sodium | | ___ mEq/L = mmol/L | | |
| Haematocrit | | ___ % | | | Potassium | | ___ mEq/L = mmol/L | | |
| Platelets | | ___ /mm³ | ___ G/L (= x10⁹/L) | | Procalcitonin | | ___ ng/mL | ___ µg/L | |
| APTT/APTR | | ___ seconds | | | CRP | | ___ mg/L | | |
| PT (seconds) | | ___ seconds | | | LDH | | ___ IU/L | | |
| INR | | | | | Creatine kinase | | ___ IU/L | __ UKAT/L | |
| ALT/SGPT | | ___ IU/L | | | Troponin | | ___ ng/mL | __ µg/L | |
| AST/SGOT | | ___ IU/L | | | ESR | | __ mm/hour | | |
| Total bilirubin | | ___ mg/L | __ µmol/L | | D-dimer | | ___ ng/mL | ___ µg/L | |
| Urea (BUN) | | ___ g/L | ___ mg/dL | ___ mmol/L | Ferritin | | ___ ng/mL | ___ µg/L | |
| Lactate | | ___ mg/dL | ___ mmol/L | | IL-6 | | ___ pg/mL | | |

## 2d. MEDICATION

Please record if the woman received any of these medications on the date stated on this follow-up form. Please select as many treatments as are applicable.

**Oral/orogastric fluids.** Include any fluids delivered clinically but not woman drinking fluids normally.

***Intravenous fluids.*** Record "Yes" if on the calendar day of follow up, the woman received intravenous fluids for rehydration, maintenance requirements or resuscitation.

**Antiviral.** Record "Yes" if on the calendar day of admission, the woman received an antiviral. Please which drug was taken among those listed. Specify other drug (e.g. remdesivir, etc.) in the free text field.

**Corticosteroid.** Record "Yes" if on the calendar day of follow up, the woman received a corticosteroid (e.g. hydrocortisone, decadron, prednisone, beclomethasone, budesonide, etc.). Select all applicable routes of administration; record the maximum daily dose. Leave blank if it does not apply.

**Antibiotic.** Record "Yes" if on the calendar day of follow up, the woman received an antibiotic

**2d. MEDICATION At any time during this 24-hour hospital day, did the patient receive:**

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

**Antiviral?** ☐Yes ☐No ☐Unknown **If yes:** ☐Ribavirin ☐Lopinavir/Ritonavir ☐Neuraminidase inhibitor ☐Interferon alpha ☐Interferon beta ☐Other, specify: _____

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

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

**Antibiotic?** ☐Yes ☐No ☐Unknown **Antifungal agent?** ☐Yes ☐No ☐Unknown

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

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

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

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

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

**Systemic anticoagulation** ☐Yes ☐No ☐Unknown

(e.g. levofloxacin, meropenem, ceftriaxone, vancomycin, etc.).

**Antifungal.** Record "Yes" if on the calendar day of follow up, the woman received an antifungal (e.g. amphotericin, fluconazole).

**Antimalarial agent.** Record "Yes" if on the calendar day of follow up, the woman received an antimalarial (e.g. artemisinin-based combination therapies, hydroxychloroquine, chloroquine, artesunate, sulfadoxine-pyrimethamine, etc.).

**Experimental agent.** Record "Yes" if on the calendar day of follow up, the woman received an experimental agent for treatment not listed above as an antiviral (e.g. azithromycin, hydroxychloroquine, IVIg, immunomodulators, etc.).

**For non-steroidal anti-inflammatory (NSAID).** Record "Yes" if on the calendar day of follow up, the woman received an NSAID (e.g. ibuprofen, ketorolac, naproxen, etc.). Do not include low-dose aspirin taken for cardioprotective purposes.

**Angiotensin converting enzyme inhibitors (ACE inhibitors).** Record "Yes" if woman reports taking any ACE inhibitor (e.g. captopril, lisinopril, etc.) on the calendar day of follow up.

**Angiotensin II receptor blockers (ARBs).** Record "Yes" if woman reports taking any ARB (e.g. losartan, valsartan) on the calendar day of follow up.

**Systemic anticoagulation.** Record "Yes" if on the calendar day of follow up, the woman received systemic anticoagulation (e.g. heparin in any formulation, warfarin, etc.).

## 2e. SUPPORTIVE CARE

Please record all treatments received on the calendar day of follow up.

**ICU.** Record "Yes" if on the calendar day of follow up, the woman was admitted to the intensive care or high dependency unit on the day of admission.

**Oxygen therapy.** Please provide details of any supplemental oxygen therapy given. Record "Yes" if on the calendar day of follow up the woman received oxygen therapy (e.g. low-flow, high-flow, face mask). If the woman received oxygen therapy, record the highest flow administered on the calendar day. Leave blank if it does not apply. If the woman received oxygen therapy, record the source of oxygen. If multiple sources used, select the most common source. Leave blank if it does not apply. If the woman received oxygen therapy, record which interface was used. If multiple interfaces used, select the primary interface used. Leave blank if it does not apply.

**2d. MEDICATION At any time during this 24-hour hospital day, did the patient receive:**

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

**Antiviral?** ☐Yes ☐No ☐Unknown **If yes:** ☐Ribavirin ☐Lopinavir/Ritonavir ☐Neuraminidase inhibitor ☐Interferon alpha ☐Interferon beta ☐Other, specify: _____

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

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

**Antibiotic?** ☐Yes ☐No ☐Unknown **Antifungal agent?** ☐Yes ☐No ☐Unknown

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

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

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

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

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

**Systemic anticoagulation** ☐Yes ☐No ☐Unknown

**2e. SUPPORTIVE CARE At any time during this 24-hour hospital day, did the patient receive:**

**ICU or high dependency unit admission?** ☐Yes ☐No ☐Unknown

**Date of ICU/HDU admission** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐Unknown

**ICU/HDU discharge date** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐Not discharged yet ☐Unknown

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

**$O_2$ flow:** ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ > 15 L/min ☐Unknown

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

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

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

**Invasive ventilation (any)?** ☐Yes ☐No ☐Unknown **If yes, what were the following values closest to 08:00:** PEEP (cm $H_2O$) _____; $FiO_2$ (%) _____; Plateau pressure (cm $H_2O$) _____; $PaCO_2$ _____; $PaO_2$_____

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

**Prone position?** ☐Yes ☐No ☐Unknown

**Inotropes/vasopressors?** ☐Yes ☐No ☐Unknown

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

**Non-invasive ventilation.** Record "Yes" if on the calendar day of follow up the woman received non-invasive ventilation. Please include any positive-pressure treatment given via a tight-fitted mask. This can be a continuous positive pressure (CPAP) or a pressure that changes with the breathing cycle (BIPAP).

**Invasive ventilation.** Record "Yes" if on the calendar day of follow up the woman received invasive ventilation (e.g. mechanical ventilation with a ventilator). Do not include women who are breathing independently via a tracheostomy.

**PEEP.** If on the calendar day of follow up the woman received invasive ventilation, record the positive end-expiratory pressure (PEEP) ($cmH_2O$) measured closest to 08:00.

**$FiO_2$.** If on the calendar day of follow up the woman received invasive ventilation, record the fraction of inspired oxygen ($FiO_2$) (%) measured closest to 08:00. If on the calendar day the woman received invasive ventilation, record the plateau pressure ($cmH_2O$) measured closest to 08:00.

**$PaCO_2$.** If on the calendar day of follow up the woman received invasive ventilation and had an arterial blood gas drawn, record the arterial partial pressure of carbon dioxide ($PaCO_2$) recorded closest to 08:00.

**$PaO_2$.** If on the calendar day of follow up the woman received invasive ventilation and had an *arterial* blood gas drawn, record the arterial partial pressure of oxygen ($PaO_2$) recorded closest to 08:00.

**Extracorporeal support.** Record "Yes" if on the calendar day of follow up the woman received extracorporeal support (e.g. ECMO, ECLS, E-CPR).

**Prone position.** Please record for any ventilated women if they have been in the prone position to aid their ventilation.

**Inotropes/vasopressors.** Record "Yes" if on the calendar day of follow up the woman received inotropes/vasopressors as a continuous infusion (e.g. epinephrine/adrenaline, norepinephrine, vasopressin, etc.).

**Renal replacement therapy or dialysis.** This includes any form of continuous renal replacement therapy or intermittent haemodialysis.

**2e. SUPPORTIVE CARE At any time during this 24-hour hospital day, did the patient receive:**

**ICU or high dependency unit admission?** ☐Yes ☐No ☐Unknown
**Date of ICU/HDU admission** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐Unknown
**ICU/HDU discharge date** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐Not discharged yet ☐Unknown
**Oxygen therapy?** ☐Yes ☐No ☐Unknown **If yes,** complete all below:
**$O_2$ flow:** ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ > 15 L/min ☐Unknown
**Source of oxygen:** ☐Piped ☐Cylinder ☐Concentrator ☐Unknown
**Interface:** ☐Nasal prongs ☐HF nasal cannula ☐Mask ☐Mask with reservoir ☐CPAP/NIV mask ☐Unknown
**Non-invasive ventilation?** (e.g. BIPAP, CPAP) ☐Yes ☐No ☐Unknown
**Invasive ventilation (any)?** ☐Yes ☐No ☐Unknown **If yes, what were the following values closest to 08:00:** PEEP ($cm\ H_2O$) _____; $FiO_2$ (%) _____; Plateau pressure ($cm\ H_2O$) _____; $PaCO_2$ _____; $PaO_2$_____
**Extracorporeal (ECMO) support?** ☐Yes ☐No ☐Unknown
**Prone position?** ☐Yes ☐No ☐Unknown
**Inotropes/vasopressors?** ☐Yes ☐No ☐Unknown
**Renal replacement therapy (RRT) or dialysis?** ☐Yes ☐No ☐Unknown

## 2f. FETAL HEART RATE (DAILY)

Please provide the most abnormal fetal heart rate for that day (between 00:00 to 24:00), for women currently pregnant upon admission, as beats per minute.

| 2f. FETAL HEART RATE | |
|---|---|
| **Fetal heart rate (record most abnormal value between 00:00 to 24:00)** | **(FHR):** [_ _][_ _][_ _] beats/min |

## 2g. TREATMENT DURING HOSPITALIZATION

Please record all treatments received at any point during the hospitalisation.

**Tocolysis.** Record "Yes" if at any time during hospitalisation the woman received any tocolytic agent (e.g. indomethacin, nifedipine, magnesium sulfate, etc) to prevent preterm labour.

**Induction of labour.** Record "Yes" if at any time during hospitalisation the woman received any treatment to induce labour, including mechanical and pharmacologic methods (e.g., misoprostol, oxytocin, cervical Foley).

**Blood transfusion.** Record "Yes" if at any time during hospitalisation the woman received any transfusion of blood products.

| 2g. TREATMENT DURING HOSPITALIZATION At ANY time during hospitalization, did the patient receive/undergo: | |
|---|---|
| **Tocolysis** | ☐Yes ☐No ☐Unknown |
| **Induction of labour** | ☐Yes ☐No ☐Unknown |
| **Blood transfusion** | ☐Yes ☐No ☐Unknown |

## MODULE 3. COMPLETE AT DISCHARGE/DEATH

This page should be completed once a woman is discharged or has died using all available data throughout their stay in hospital.

## 3a. DIAGNOSTIC/PATHOGEN TESTING

**Chest X-ray/CT.** Please select "Yes" if a chest X-ray or thoracic CT was performed at any point during the woman's hospital stay.

**Infiltrates present.** Please tick that infiltrates are present if they are reported as present by a radiologist. You can also select "Yes" if you are qualified to assess the images, or if a senior member of the clinical team looking after the woman has documented that the images showed "infiltrates", "consolidation" or "radiological signs of pneumonia".

**Pathogen testing.** For each pathogen, select whether the test was positive (the pathogen was found), negative (the pathogen was not found) or the test was not done. Where a pathogen was identified, please specify the organism identified as precisely as possible.

## 3b. COMPLICATIONS

Please select all that were present at any time during the hospital stay.

**Shock.** An acute, life-threatening circulatory failure. Signs can include tachycardia, tachypnoea, hypotension and altered mental state.

**Seizure.** A seizure, convulsion or "fit" is an involuntary rhythmic contraction of muscles. Select "Yes" for any seizure regardless of cause (e.g. febrile, due to epilepsy, or eclampsia).

**Meningitis/encephalitis.** Inflammation of the meninges or the brain. Select "Yes" if diagnosed clinically, radiologically or microbiologically.

**Anaemia.** Select "Yes" if haemoglobin levels were lower less than 11.0 g/dl or 110 g/L or 6.8 mmol/L in the first, less than 10.5 g/dl or 105 g/L or 6.52 mmol/L in the second and third trimester

**Cardiac arrythmia.** Record "Yes" if at any time during hospitalization the woman was diagnosed with a cardiac arrhythmia (e.g. ventricular tachycardia, ventricular fibrillation, long QT, atrial fibrillation, atrial flutter, atrial tachycardia, atrio-ventricular tachycardia, atrioventricular block of any degree, bradycardia, etc.). Do NOT include premature

**PREGNANCY MODULE 3. Complete at discharge/death**

**3a. DIAGNOSTIC/PATHOGEN TESTING**

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

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

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

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

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

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

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

**Falciparum malaria:** ☐Positive ☐Negative ☐Not done

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

**3b. COMPLICATIONS At any time during hospitalization did the patient experience:**

| | | | |
|---|---|---|---|
| **Shock** | ☐Yes ☐No ☐Unknown | **Bacteraemia** | ☐Yes ☐No ☐Unknown |
| **Seizure** | ☐Yes ☐No ☐Unknown | **Bleeding** | ☐Yes ☐No ☐Unknown |
| **Meningitis/encephalitis** | ☐Yes ☐No ☐Unknown | **Endocarditis** | ☐Yes ☐No ☐Unknown |
| **Anaemia** | ☐Yes ☐No ☐Unknown | **Myocarditis/pericarditis** | ☐Yes ☐No ☐Unknown |
| **Cardiac arrhythmia** | ☐Yes ☐No ☐Unknown | **Acute renal injury** | ☐Yes ☐No ☐Unknown |
| **Cardiac arrest** | ☐Yes ☐No ☐Unknown | **Pancreatitis** | ☐Yes ☐No ☐Unknown |
| **Pneumonia** | ☐Yes ☐No ☐Unknown | **Liver dysfunction** | ☐Yes ☐No ☐Unknown |
| **Bronchiolitis** | ☐Yes ☐No ☐Unknown | **Cardiomyopathy** | ☐Yes ☐No ☐Unknown |
| **Stroke: ischaemic stroke** | ☐Yes ☐No ☐Unknown | **ARDS** | ☐Yes ☐No ☐Unknown |
| **Stroke: intracerebral haemorrhage** | ☐Yes ☐No ☐Unknown | | |
| **Other** | ☐Yes ☐No ☐Unknown If Yes, specify:_____ | | |

ventricular contractions, premature atrial contractions, sinus pauses, or variations in rhythm due to respirations.

**Cardiac arrest.** Record "Yes" if the woman had a sudden lack of a palpable pulse, with loss of consciousness and absent breathing, preceded or accompanied by one or more of the following signs/symptoms: abnormal breathing, chest pain, shortness of breath, nausea, fatigue, blackouts, dizziness, weakness.

**Pneumonia.** Select 'Yes" if radiologically diagnosed pneumonia or if the woman's discharge diagnosis is recorded as pneumonia. Record "Yes" if at any time during hospitalization the woman was diagnosed with pneumonia from any pathogen (e.g. bacterial, viral, fungal, or unknown). This includes ventilator-associated pneumonia.

**Bronchiolitits.** This is a clinical diagnosis, generally in children < 2 years old.

**Acute respiratory distress syndrome (ARDS):** Defined according to Berlin criteria as:

- Occurring within 1 week of a known clinical insult or worsening respiratory symptoms.
- Bilateral radiological opacities not fully explained by effusions, lobar/lung collapse, or nodules.
- Respiratory failure not fully explained by cardiac failure or fluid overload.

**Stroke.**

- **Ischaemic stroke.** Record "yes" if the woman has an acute neurological dysfunction caused by focal infarction at single or multiple sites of the brain.
- **Intracerebral haemorrhage.** Record "yes" if the woman had a focal collection of blood within the brain parenchyma or ventricular system that is not caused by trauma that may lead to acute neurological dysfunction.

**Bacteraemia.** Growth of bacteria on a blood culture. Select "No" if the only bacteria grown were believed to be a skin contaminant.

**Bleeding.** Please record "Yes" for haemorrhage from any site.

**Endocarditis.** Inflammation of the endocardium (inner lining of the heart). Diagnosis is according to modified Duke criteria, using evidence from microbiological results, echocardiogram and clinical signs.

**Myocarditis/pericarditis.** Inflammation of the heart or pericardium (outer lining of the heart). Diagnosis can be reached from results of imaging, ECG, biochemistry and haematology results.

| 3b. COMPLICATIONS At any time during hospitalization did the patient experience: | | | |
|---|---|---|---|
| **Shock** | ☐Yes ☐No ☐Unknown | **Bacteraemia** | ☐Yes ☐No ☐Unknown |
| **Seizure** | ☐Yes ☐No ☐Unknown | **Bleeding** | ☐Yes ☐No ☐Unknown |
| **Meningitis/encephalitis** | ☐Yes ☐No ☐Unknown | **Endocarditis** | ☐Yes ☐No ☐Unknown |
| **Anaemia** | ☐Yes ☐No ☐Unknown | **Myocarditis/pericarditis** | ☐Yes ☐No ☐Unknown |
| **Cardiac arrhythmia** | ☐Yes ☐No ☐Unknown | **Acute renal injury** | ☐Yes ☐No ☐Unknown |
| **Cardiac arrest** | ☐Yes ☐No ☐Unknown | **Pancreatitis** | ☐Yes ☐No ☐Unknown |
| **Pneumonia** | ☐Yes ☐No ☐Unknown | **Liver dysfunction** | ☐Yes ☐No ☐Unknown |
| **Bronchiolitis** | ☐Yes ☐No ☐Unknown | **Cardiomyopathy** | ☐Yes ☐No ☐Unknown |
| **Stroke: ischaemic stroke** | ☐Yes ☐No ☐Unknown | **ARDS** | ☐Yes ☐No ☐Unknown |
| **Stroke: intracerebral haemorrhage** | ☐Yes ☐No ☐Unknown | | |
| **Other** | ☐Yes ☐No ☐Unknown<br>If Yes, specify:_____ | | |

**Acute renal injury.** Record "Yes" if at any time during hospitalization the woman was diagnosed with acute renal or kidney injury (AKI) or renal insufficiency. Acute renal injury for non-pregnant individuals is defined as any of:

- Increase in serum creatinine by ≥ 0.3 mg/dL (≥ 26.5 µmol/L) within 48 hours.
- Increase in serum creatinine to ≥ 1.5 times baseline, which is known or presumed to have occurred within the prior 7 days.
- Urine volume < 0.5 mL/kg/hour for 6 hours.

During pregnancy, the following criteria can be considered:

- Serum creatinine ≥ 1mg/dL
- Rapid increase of 0.5 mg/dL above baseline in 48 hours

For the post-abortion (1st trimester) individuals, the non-pregnant criteria can be followed.

**Pancreatitis.** Inflammation of the pancreas, diagnosed from clinical, biochemical, radiological or histological evidence.

**Liver dysfunction.** Record "Yes" if at any time during hospitalization the woman was diagnosed with liver dysfunction or failure, including pregnancy-related liver disorders (eg intrahepatic cholestasis of pregnancy, acute fatty liver of pregnancy, HELLP). Liver dysfunction or disorders during pregnancy in general can having the following findings: an increase in alanine transaminase or aspartate transaminase; clinical jaundice; hyperbilirubinemia (blood bilirubin level, elevated fasted total bile acids, or elevated prothrombin time).

**Cardiomyopathy.** Record "Yes" if at any time during hospitalization the woman was diagnosed with cardiomyopathy or heart failure.

**Other.** Please report any other serious complications during this woman's stay in hospital. For pregnancy-related complications use section 3.f.

| 3b. COMPLICATIONS At any time during hospitalization did the patient experience: | | | |
|---|---|---|---|
| **Shock** | ☐Yes ☐No ☐Unknown | **Bacteraemia** | ☐Yes ☐No ☐Unknown |
| **Seizure** | ☐Yes ☐No ☐Unknown | **Bleeding** | ☐Yes ☐No ☐Unknown |
| **Meningitis/encephalitis** | ☐Yes ☐No ☐Unknown | **Endocarditis** | ☐Yes ☐No ☐Unknown |
| **Anaemia** | ☐Yes ☐No ☐Unknown | **Myocarditis/pericarditis** | ☐Yes ☐No ☐Unknown |
| **Cardiac arrhythmia** | ☐Yes ☐No ☐Unknown | **Acute renal injury** | ☐Yes ☐No ☐Unknown |
| **Cardiac arrest** | ☐Yes ☐No ☐Unknown | **Pancreatitis** | ☐Yes ☐No ☐Unknown |
| **Pneumonia** | ☐Yes ☐No ☐Unknown | **Liver dysfunction** | ☐Yes ☐No ☐Unknown |
| **Bronchiolitis** | ☐Yes ☐No ☐Unknown | **Cardiomyopathy** | ☐Yes ☐No ☐Unknown |
| **Stroke: ischaemic stroke** | ☐Yes ☐No ☐Unknown | **ARDS** | ☐Yes ☐No ☐Unknown |
| **Stroke: intracerebral haemorrhage** | ☐Yes ☐No ☐Unknown | | |
| **Other** | ☐Yes ☐No ☐Unknown<br>If Yes, specify:_____ | | |

## 3c. MEDICATION

Please record if the woman received any of these medications during their stay in hospital or as a medication to take home on discharge.

**Oral/orogastric fluids.** Include any fluids delivered clinically but not woman drinking fluids normally.

**Intravenous fluids.** Record "Yes" if at any point during the woman's hospital stay, the woman received intravenous fluids for rehydration, maintenance requirements or resuscitation.

**Antiviral.** Record "Yes" if at any point during the woman's hospital stay, the woman received an antiviral. Please indicate which drug was taken among those listed. Specify other drug (e.g. remdesivir, etc.) in the free text field.

**Corticosteroid.** Record "Yes" if at any point during the woman's hospital stay, the woman received a corticosteroid (e.g. hydrocortisone, decadron, prednisone, beclomethasone, budesonide, etc.). Select all applicable routes of administration; record the maximum daily dose. Leave blank if it does not apply.

**Antibiotic.** Record "Yes" if at any point during the woman's hospital stay, the woman received an antibiotic (e.g. levofloxacin, meropenem, ceftriaxone, vancomycin, etc.).

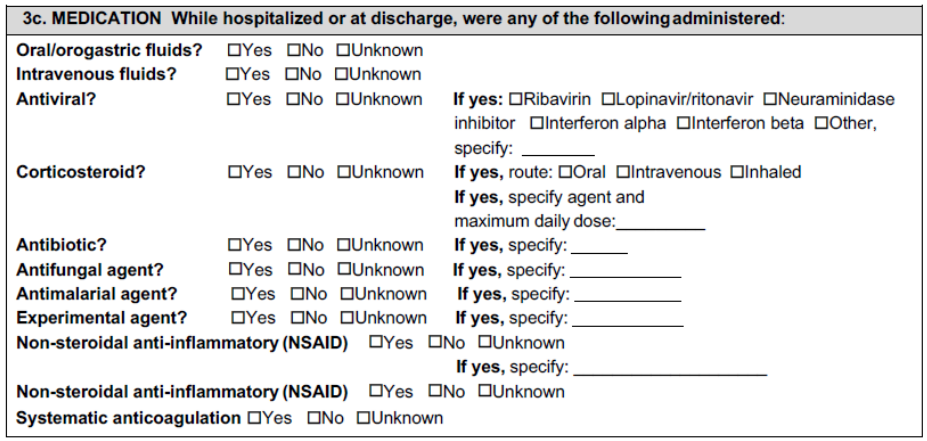
**Antifungal.** Record "Yes" if at any point during the woman's hospital stay, the woman received an antifungal (e.g. amphotericin, fluconazole).

**Antimalarial agent.** Record "Yes" if at any point during the woman's hospital stay, the woman received an antimalarial (e.g. artemisinin-based combination therapies, hydroxychloroquine, chloroquine, artesunate, sulfadoxine-pyrimethamine, etc.).

**Experimental agent.** Record "Yes" if at any point during the woman's hospital stay, the woman received an experimental agent for treatment not listed above as an antiviral (e.g. azithromycin, hydroxychloroquine, IVIg, immunomodulators, etc.).

**For non-steroidal anti-inflammatory (NSAID).** Record "Yes" at any point during the woman's hospital stay, the woman received an NSAID (e.g. ibuprofen, ketorolac, naproxen, etc.). Do not include low-dose aspirin taken for cardioprotective purposes.

**Systemic anticoagulation.** Record "Yes" if on the calendar day of admission, the woman received systemic anticoagulation (e.g. heparin in any formulation, warfarin, etc.



**3c. MEDICATION While hospitalized or at discharge, were any of the following administered:**

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

## 3d. SUPPORTIVE CARE

**ICU.** Please state whether the woman was admitted to ICU or a high dependency unit at any point during their stay in hospital. Please report the total number of days the woman was in ICU or a high dependency unit.

Please state the date the were admitted to ICU. If they died in ICU or were transferred from your site's ICU to another hospital's ICU, please select "in ICU at outcome", otherwise please record the date they were discharged from ICU.

**Oxygen therapy.** Please provide details of any supplemental oxygen therapy given. Record "Yes" if on any day during the hospitalization the woman received oxygen therapy (e.g. low-flow, high-flow, face mask). If the woman received oxygen therapy, record the highest flow administered on the calendar day. Leave blank if it does not apply. If the woman received oxygen therapy, record the source of oxygen. If multiple sources used, select the most common source. Leave blank if it does not apply. If the woman received oxygen therapy, record which interface was used. If multiple interfaces used, select the primary interface used. Leave blank if it does not apply.

**Non-invasive ventilation.** Record "Yes" if on any day during the hospitalization the woman received non-invasive ventilation. Please include any positive-pressure treatment given via a tight-fitted mask. This can be a continuous positive pressure (CPAP) or a pressure that changes with the breathing cycle (BIPAP).

**Invasive ventilation.** Record "Yes" if on any day during the hospitalization the woman received invasive ventilation (e.g. mechanical ventilation with a ventilator). Do not include women who are breathing independently via a tracheostomy.

**Extracorporeal support.** Record "Yes" if on any day during the hospitalization the woman received extracorporeal support (e.g. ECMO, ECLS, E-CPR).

**Prone position.** Please record for any ventilated women if they have been in the prone position to aid their ventilation.

**Inotropes/vasopressors.** Record "Yes" if on any day during the hospitalization the woman received inotropes/vasopressors as a continuous infusion (e.g. epinephrine/adrenaline, norepinephrine, vasopressin, etc.).

**Renal replacement therapy or dialysis.** This includes any form of continuous renal replacement

**3d. SUPPORTIVE CARE At ANY time during hospitalization, did the patient receive/undergo:**

**ICU or high dependency unit admission?** ☐Yes ☐No ☐Unknown **If yes,** total duration: ____days

**Date of ICU admission** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐ N/A

**Date of ICU discharge** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐ In ICU at outcome ☐N/A

**Oxygen therapy?** ☐Yes ☐No ☐Unknown **If yes, complete all:** **Total duration**:_____days

**$O_2$ flow:** ☐ 1–5 L/min ☐ 6–10 L/min ☐ 11–15 L/min ☐ >15 L/min **Source of oxygen:** ☐Piped ☐Cylinder ☐Concentrator

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

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

**Invasive ventilation (any)?** ☐Yes ☐No ☐Unknown **If yes,** total duration:___ days

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

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

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

therapy or intermittent haemodialysis.

## 3e. OUTCOME

**Outcome.** Please select only one outcome for the woman.

**Outcome date.** Please indicate the date for the stated outcome (e.g., date in which the woman was discharged or died) in day/month/year form.

**Discharged alive** signifies that the woman was discharged to home alive and not for palliative care. It can mean discharge to their usual place of residence before their illness, to the home of a relative or friend, or to a social care facility, because their illness is no longer severe enough to warrant treatment in a medical facility.

**Hospitalized** signifies that the woman continues to be hospitalized without the possibility of continued data collection.

**Transfer to other facility** means they have been transferred to another facility that provides medical care. This could be a specialist centre for more intensive treatment or a step-down for rehabilitation. It does not include facilities that solely provide social care (these women should be listed as discharged alive).

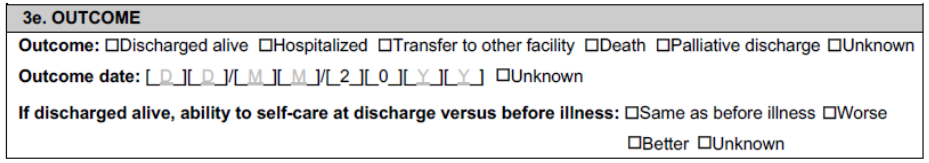
**Death** means the woman died in the hospital.

**Palliative discharge** means the woman has been discharged with the expectation that they will not recover from this illness. This could be to a specialist hospice facility, or to their usual home address with anticipatory end of life medications.

**Unknown** is to be used in cases when the woman is lost to follow-up or the outcome is unknown/undocumented.

**Outcome date.** Please state the date for the outcome listed above.

If the **woman was discharged alive**, record the woman's self-care ability at the time of discharge relative to his/her ability PRIOR to this illness (not at the time of admission).



| 3e. OUTCOME |
| --- |
| **Outcome:** ☐Discharged alive ☐Hospitalized ☐Transfer to other facility ☐Death ☐Palliative discharge ☐Unknown |
| **Outcome date:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐Unknown |
| **If discharged alive, ability to self-care at discharge versus before illness:** ☐Same as before illness ☐Worse ☐Better ☐Unknown |

**Sections 3f–3i should only be completed if delivery happened within 21 days of symptom onset**

## 3f. DELIVERY, PREGNANCY, AND MATERNAL OUTCOMES

**Delivery during admission.** Please record whether delivery occurred during the current hospital stay. Select only one outcome.

**Delivery date.** Please indicate the date when delivery occurred.

**Mode of delivery.** Please record whether delivery was vaginal or via Caesarean section.

**Onset of labour.** Please indicate whether labour onset was spontaneous, induced, Caesarean section was done before onset of labour, or whether this information is unknown/not recorded and woman is unable to confirm.

**Fetal presentation at delivery.** Please record whether foetus presented head first (cephalic), sideways (transverse) or feet first (breech).

**Amniotic fluid at delivery.** Please indicate whether amniotic fluid at delivery was clear, whether there were meconium traces, or whether this information is unknown/not recorded.

**Other maternal outcomes or pregnancy complications.** Please record whether there were any other complications related to the pregnancy or during delivery. If this information was not recorded, indicate “unknown.”

| 3f. DELIVERY, PREGNANCY AND MATERNAL OUTCOMES | | |
|---|---|---|
| **Delivery during admission** | ☐Yes ☐No | |
| **Delivery date** | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] | |
| **Mode of delivery** | ☐ Vaginal delivery<br>☐ Caesarean section | |
| **Onset of labour** | ☐ Spontaneous<br>☐ Induced<br>☐ Cesarean section before labour<br>☐ Unknown | |
| **Fetal presentation at delivery** | ☐ Cephalic ☐ Transverse ☐ Breech | |
| **Amniotic fluid at delivery** | ☐ Clear ☐ Meconium stained ☐ Unknown | |
| **Other maternal outcomes/pregnancy complications** | Gestational diabetes | ☐Yes ☐No ☐Unknown |
| | Gestational hypertension | ☐Yes ☐No ☐Unknown |
| | Anaemia (Hb < 11 g/dL) | ☐Yes ☐No ☐Unknown |
| | Hyperemesis | ☐Yes ☐No ☐Unknown |
| | Intrauterine growth restriction | ☐Yes ☐No ☐Unknown |
| | Placental previa/accreta/percreta | ☐Yes ☐No ☐Unknown |
| | Bacterial infection prior to hospital visit | ☐Yes ☐No ☐Unknown |
| | Pre-eclampsia/eclampsia | ☐Yes ☐No ☐Unknown |
| | Placental abruption | ☐Yes ☐No ☐Unknown |
| | Preterm contractions | ☐Yes ☐No ☐Unknown |
| | Preterm labour | ☐Yes ☐No ☐Unknown |
| | Preterm rupture of membranes | ☐Yes ☐No ☐Unknown |
| | Early or midterm miscarriage | ☐Yes ☐No ☐Unknown |
| | Haemorrhage | ☐Yes ☐No ☐Unknown |
| | **If haemorrhage, which type:** | ☐ Antepartum/intrapartum<br>☐ Postpartum haemorrhage<br>☐ Abortion-related |
| | Embolic disease | ☐Yes ☐No ☐Unknown |
| | Anesthetic complication | ☐Yes ☐No ☐Unknown |

## 3g. PREGNANCY STATUS AT DISCHARGE

**Pregnancy outcome.** Record how pregnancy ended. Please select only one.

**Maternal death.** Please indicate whether the woman died during hospital stay.

**If the woman died** please indicate the cause of death as recorded in the woman's medical record/death certificate. **Of note, the causes of death match the ICD coding.**

| 3g. PREGNANCY STATUS AT DISCHARGE | |
|---|---|
| **Pregnancy outcome** | ☐Undelivered<br>☐Spontaneous abortion<br>☐Induced abortion<br>☐Missed abortion<br>☐Macerated stillbirth<br>☐Fresh stillbirth<br>☐Livebirth<br>☐Post-abortion/postpartum on admission |
| **Maternal death**<br><br>**If yes, what was the underlying cause of death?** | ☐Yes ☐No<br>☐Abortive outcome<br>☐Hypertensive disorders in pregnancy, childbirth and the puerperium<br>☐Obstetric haemorrhage<br>☐Pregnancy-related infection<br>☐Other obstetric complication not included in above causes<br>☐Unanticipated complications of management (e.g. anaesthesia-related complications)<br>☐Indirect maternal death<br>☐Obstetric death of unspecified cause<br>☐Deaths from a coincidental cause (e.g. motor vehicle accident) |

## 3h. SAMPLE COLLECTION

Please record if there were any samples taken from the woman at any point during hospital stay.

**Amniotic fluid.** Indicate the test used, the date of collection and the result for any amniotic fluid sample.

**Placenta.** Indicate the test used, the date of collection and the result for any placenta sample.

**Cord blood** Indicate the test used, the date of collection and the result for any cord blood sample.

**Vaginal swab.** Indicate the test used, the date of collection and the result for any vaginal swab sample.

**Faeces/rectal swab** Indicate the test used, the date of collection and the result for any faecal sample or rectal swab sample.

**Pregnancy tissue if there was a fetal death or induced abortion.** Indicate the test used, the date of collection and the result for any tissue sample.

**Breastmilk.** Indicate the test used, the date of collection and the result for any breastmilk sample.

| 3h. SAMPLE COLLECTION | | | | |
|---|---|---|---|---|
| **Any sampling conducted? If so, please describe the test and the results** | ☐Amniotic fluid | [_test description_] | [_date of collection_] | [_____result_____] |
| | ☐Placenta | [_test description_] | [_date of collection_] | [_____result_____] |
| | ☐Cord blood | [_test description_] | [_date of collection_] | [_____result_____] |
| | ☐Vaginal swab | [_test description_] | [_date of collection_] | [_____result_____] |
| | ☐Faeces/rectal swab | [_test description_] | [_date of collection_] | [_____result_____] |
| | ☐Pregnancy tissue in the case of fetal demise/induced abortion | [_test description_] | [_date of collection_] | [_____result_____] |
| | ☐Breastmilk | [_test description_] | [_date of collection_] | [_____result_____] |

## 3i. NEONATAL OUTCOMES

Please use this section to record all outcomes relating to any live birth. If multiple pregnancy (twins or more), please complete one per neonate. Do not complete this section for stillbirths –these should be recorded under maternal outcome, section 3.g.

**Date and time of birth.** Record full date (in day/month/year form) and time of live birth (24h clock format).

**Participant ID of the mother.** Record the ID of the mother and include a single digit to indicate the neonate (if multiple pregnancy, use sequential numbers and do not repeat) Each neonate should have a unique number.

**COVID-19 lab test of foetus or neonate.** Record whether the test was performed or not; if there is no record of test having been performed indicate "unknown." If the test was performed please indicate what sample was collected, the description of the test, the date on which the sample was collected (using day/month/year form), and the result of the test.

**Apgar score at 5 minutes.** Record the 2-digit Apgar score (range 1-10).

**Gestational age.** Record gestational age in weeks and days at birth.

**Birth weight.** Record neonate's weight at birth in grams.

**Respiratory distress syndrome.** Record whether neonate experienced respiratory distress at birth.

**Neonatal outcome.** Indicate whether the neonate was discharged healthy, with complications or sequelae (including details on the type of complications), whether the neonate was referred to a specialist or another health centre (including details describing type of specialist or hospital), whether the neonate died (including date of death using day/month/year form) or whether there is no indication on neonatal outcome and it cannot be retrieved from the woman. Please check only one option.

| 3i. NEONATAL OUTCOMES | |
|---|---|
| **Date of birth** [DD/MM/YYYY]<br>**Time of birth** [e.g. 14:21] | [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]<br>[____:____] |
| **Participant ID of the mother:** | [___][___][___][___][___]-- [___][___][___][___] –<br>[__Single digit Baby ID_]* *Complete one form per neonate |
| **COVID-19 lab test of foetus or neonate** | ☐Performed ☐Not performed ☐Unknown<br>If yes: [_sample collected__] [_test description__][_date of collection__ ]<br>[_____result_____] |
| **Apgar score at 5 minutes** | Score: [___][___] |
| **Gestational age** | Weeks: [___][___] Days: [_____] |
| **Birth weight** | Grams: [___][___][___][___] |
| **Respiratory distress syndrome** | ☐Yes ☐No ☐Unknown |

| | |
|---|---|
| **Neonatal outcome** | ☐Discharged healthy<br>☐Discharged with complications/sequelae<br>Details: [_____]<br>☐Clinical referral to specialist ward /other hospital<br>Details: [_____]<br>☐Death Date of death: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_]<br>☐Unknown |

**If neonate died** please indicate the primary cause of death as recorded in the newborn's medical record/death certificate.

**Any congenital anomalies.** Record any and all congenital anomalies, if present. If more than one, check off as many boxes as needed. If there were none, leave this blank.

| | |
|---|---|
| **If neonate died, primary cause of death** | ☐Preterm/low birth weight<br>☐Birth asphyxia<br>☐Infection<br>☐Birth trauma<br>☐Congenital/birth defects<br>☐Other<br>☐Unknown |
| **Any congenital anomalies** | ☐Neural tube defects<br>☐Microcephaly<br>☐Congenital malformations of ear<br>☐Congenital heart defects<br>☐Orofacial clefts<br>☐Congenital malformations of digestive system<br>☐Congenital malformations of genital organs<br>☐Abdominal wall defects<br>☐Chromosomal abnormalities<br>☐Reduction defects of upper and lower limbs<br>☐Talipes equinovarus/clubfoot |