New Subject Data CRF

Introduction

Age in whole years of subject at the time of detection of novel coronavirus infection (SARS-CoV-2) or development of COVID-19 illness _____

For reporting on adult patients (19 years of age and older) please do not report on this form! Instead, please report as follows:

- If the patient has already been enrolled in the CARRA Registry, please report this to the CARRA Registry as an Event of Special Interest - your site will be paid for report as with any ESI.
- For all countries except Europe, use the COVID-19 Global Rheumatology Alliance Provider Registry.
- If you are from Europe (except Germany), use the EULAR- COVID-19 Database
- If you are from Germany, we have been advised that they will be initiating their own registry

Severity

Please indicate the **most extreme level** of illness that the patient has so far experienced from COVID-19

- ◯ Asymptomatic: No signs or symptoms of COVID-19. Laboratory evidence only of SARS-CoV-2 infection
- ◯ Mild: no interventions, including no change of medications or treatment, have been required (CTCAE Grade 1)
- ◯ Moderate: some treatment or clinical action taken, such as stopping or starting medications, has been required (CTCAE Grade 2)
- ◯ Severe but not immediately life-threatening: hospitalization and treatments, without intensive-care level therapy, has been required (CTCAE Grade 3)
- ◯ Life-threatening consequences: intensive-care level or similar therapy has been required (CTCAE Grade 4)
- ◯ Death (CTCAE Grade 5)

Date of death

_____

(YYYY-MM-DD)

Please indicate the current outcome of illness related to COVID-19

- ◯ Recovering or resolving
- ◯ Fully recovered or resolved
- ◯ Not yet recovering or resolving
- ◯ Unknown

Date of resolution of COVID-19 related symptoms

_____

(YYYY-MM-DD)

Please indicate any problems or sequelae the subject experienced that may be related to COVID-19 illness

- ☐ Minor or short-term disability or incapacity, including temporary limitation on activities
- ☐ Prolonged hospitalization
- ☐ Significant or persistent disability or incapacity
- ☐ Congenital anomaly or birth defect
- ☐ Other important problem, sequelae, or medical event

Specify: Other problems or sequelae

Were any medications that the patient takes for their rheumatic/autoimmune disease stopped or modified PRIOR TO recognized onset of SARS-CoV-2 infection or
COVID-19 illness?

- ◯ Yes
- ◯ No
- ◯ Unknown

Were any medications that the patient takes for their rheumatic/autoimmune disease stopped or modified AFTER recognized onset of SARS-CoV-2 infection or COVID-19 illness?

- ◯ Yes
- ◯ No
- ◯ Unknown

COVID19_STATUS

SEVERITY_STATUS

Did the patient experience any serious complications from COVID-19 illness, including secondary infections such as influenza, sepsis and other serious infections, major organ involvement (e.g. acute respiratory distress syndrome, myocarditis or cardiac involvement), Cytokine Release Syndrome/MAS, etc.

- ◯ Yes
- ◯ No
- ◯ Unknown

Serious COVID-19 Complications

Please indicate if the patient has had any significant complications of COVID-19 illness

- ◯ Acute respiratory distress syndrome (ARDS)
- ◯ Sepsis
- ◯ Influenza co-infection
- ◯ Other co-infection or secondary infection
- ◯ Myocarditis or heart failure
- ◯ Cytokine release syndrome, including Macrophage Activation Syndrome (MAS) or Hemophagocytic Lymphohistiocytosis (HLH)
- ◯ Hemolytic anemia
- ◯ Other significant complication

Specify: other co-infection or secondary infection

Specify other significant complication

Diagnostic data

Diagnostic data

Sex of patient

- ◯ Male
- ◯ Female
- ◯ Other

Gender identity of patient

- ◯ Male identity
- ◯ Female identity
- ◯ Trans Male/Trans Man
- ◯ Trans Female/Trans Woman
- ◯ Genderqueer/Gender non-conforming
- ◯ Different/other gender identity

Date of birth

_____
(YYYY-MM-DD)

Age (in years) at initial symptoms of COVID-19 illness

_____

Age (in years) at asymptomatic SARS-CoV-2 infection

_____

Approximate date of diagnosis of asymptomatic SARS-CoV-2 infection

Month

- ◯ UNK
- ◯ January
- ◯ February
- ◯ March
- ◯ April
- ◯ May
- ◯ June
- ◯ July
- ◯ August
- ◯ September
- ◯ October
- ◯ November
- ◯ December

Year

- ◯ 2019
- ◯ 2020

Date of initial symptoms of COVID-19 illness

_____

(YYYY-MM-DD)

Date of diagnosis of COVID-19 illness

_____

(YYYY-MM-DD)

Infection Acquisition: In the 14 days before onset of illness did the patient have any of the following? (Check all that apply)

- ☐ History of travel to an area with documented cases of COVID-19 infection
- ☐ Close contact with a confirmed or probable case of COVID-19 infection
- ☐ Presence in a healthcare facility where COVID-19 infections have been managed
- ☐ None of the above (community acquired)
- ☐ Unknown
- ☐ Other

COVID-19 other infection acquisition, please specify. Please DO NOT include any patient or family names or other direct identifiers (may include dates)

_____

COVID-19 Diagnosis: Location

- ☐ Hospital or other inpatient facility
- ☐ Outpatient facility
- ☐ Emergency department
- ☐ Home or mobile/drive-through (standalone) testing
- ☐ Other
- ☐ Unknown

What is the basis for diagnosis of COVID-19 illness?

- ◯ Presumptive diagnosis based on signs and symptoms only
- ◯ Probable or confirmatory testing, including labs, imaging, and other diagnostic modalities
- ◯ Unsure

Basis for COVID-19 diagnosis

Diagnostic modalities | CONFIRMED POSITIVE laboratory testing

- ☐ PCR testing
- ☐ Metagenomic testing
- ☐ Antibody testing
- ☐ Other laboratory testing

Diagnostic modalities | PROBABLE POSITIVE laboratory testing

- ☐ PCR testing
- ☐ Metagenomic testing
- ☐ Antibody testing
- ☐ Other laboratory testing

Diagnostic modalities | Specific radiographic imaging

- ☐ CT scan (conventional)
- ☐ High-resolution CT scan
- ☐ CT-PET scan
- ☐ MRI
- ☐ Nuclear scan
- ☐ Plain radiographs (X-rays)
- ☐ Ultrasound
- ☐ Other imaging

Diagnostic modalities | Other diagnostic testing

_____

Specify other COVID-19 diagnostic laboratory results. Please indicate if results are confirmed or probable, if this is known.

_____

Specify other COVID-19 diagnostic imaging

_____

Clinical signs and/or symptoms during COVID-19 illness
(leave unchecked for 'None')

- ☐ Fever, including history of fever
- ☐ Cough (productive or nonproductive)
- ☐ Hemoptysis
- ☐ Sore throat/pharyngitis
- ☐ Runny nose/rhinorrhea
- ☐ Conjunctivitis
- ☐ Ear pain
- ☐ Anosmia or hyposmia (loss or significant diminution of smell)
- ☐ Dysgeusia or hypogeusia (loss or significant diminution of taste)
- ☐ Wheezing
- ☐ Shortness of breath/dyspnea
- ☐ Muscle aches/myalgia
- ☐ Joint pain/arthralgia
- ☐ Chest pain
- ☐ Fatigue and/or malaise
- ☐ Headache
- ☐ Altered mental status, irritability, confusion
- ☐ Seizures
- ☐ Abdominal pain
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Skin rash
- ☐ Skin ulceration
- ☐ Lymphadenopathy
- ☐ Other
- ☐ Unknown

Specify other clinical signs and/or symptoms: _____

HIDEMSG_STATUS _____

COVID-19 Treatment

Based upon the subject's severity level that you have reported, this section can be skipped. Please click 'Next' to proceed.

Did the patient receive any treatment for COVID-19 illness?

- ◯ Yes
- ◯ No
- ◯ Unsure

In which settings did the patient receive treatment for COVID-19 illness:

- ☐ At home
- ☐ Ambulatory (e.g. in clinic, short ED stay)
- ☐ Hospital (e.g. observation stay, inpatient, prolonged ED stay)
- ☐ Unknown

COVID-19 Medications

Did the patient receive any medications for treatment of COVID-19 illness?

- ◯ Yes
- ◯ No
- ◯ Unknown

Medications given for COVID-19 illness:
(Only include medications given as treatment for this infection. Treatments for underlying rheumatic /autoimmune disease are collected in the next section).

(Check all that apply)

- ☐ Remdesivir
- ☐ Lopinavir/ritonavir
- ☐ Anti-malarials (e.g. chloroquine, hydroxychloroquine)
- ☐ IL-1 inhibitors (e.g. anakinra, canakinumab, rilonacept)
- ☐ IL-6 inhibitors (e.g. tocilizumab, sarilumab, siltuximab)
- ☐ Bevacizumab
- ☐ JAK inhibitors (e.g. tofacitinib, baricitinib, upadacitinib)
- ☐ Serpin inhibitors
- ☐ Ciclesonide
- ☐ Glucocorticoids
- ☐ IVIG (intravenous immunoglobulin, not SARS-COV-2 specific)
- ☐ Favipiravir
- ☐ Oseltamivir
- ☐ Azithromycin
- ☐ Plasma from recovered patients
- ☐ Other

Additional information regarding COVID-19 medication treatment:
Please DO NOT include any patient or family names or other direct identifiers (may include dates).

_____

Hospitalizations and Prolonged ED Stays

Hospitalization type

- ○ Prolonged ED stay
- ○ Regular care hospital ward or department
- ○ Intensive care unit (ICU)
- ○ Rehabilitation or convalescent care hospital

Start Date

_____
(YYYY-MM-DD)

End Date

_____
(YYYY-MM-DD)

Please indicate if the patient received any of the following medical treatments or procedures:

- ☐ Supplemental oxygen
- ☐ Non-invasive ventilation (e.g. CPAP, BiPAP, high-flow oxygen)
- ☐ Mechanical ventilation
- ☐ Chest tubes
- ☐ Central lines
- ☐ ECMO
- ☐ Dialysis
- ☐ Plasma exchange
- ☐ RBC transfusions or other blood products
- ☐ Other significant or invasive treatments of procedures

Other treatment notes:

Please DO NOT include any patient names or other direct identifiers (may include dates).

Rheumatic/Autoimmune Disease & Treatments

Primary rheumatic/autoimmune diagnosis(es)

- [ ] Juvenile Idiopathic Arthritis
- [ ] Rheumatoid Arthritis
- [ ] Systemic Lupus Erythematosus (SLE) or Mixed Connective Tissue Disease (MCTD)
- [ ] Juvenile Inflammatory Myopathies, e.g. Juvenile dermatomyositis, Juvenile polymyositis
- [ ] Anti-phospholipid antibody syndrome
- [ ] Autoimmune brain disease, e.g. AE, CNS vasculitis, NMO, MOG
- [ ] Autoimmune eye disease (Primary, NOT associated with other rheumatic disease such as JIA), e.g. idiopathic uveitis or retinitis
- [ ] Behcet's disease
- [ ] Chronic nonbacterial osteomyelitis (CNO) / Chronic recurring multifocal osteomyelitis (CRMO)
- [ ] Genetic vasculopathies, e.g. DADA2, SAVI
- [ ] IgG4-related disease
- [ ] Inflammatory bowel disease, e.g. Crohn's disease, ulcerative colitis
- [ ] Localized Scleroderma
- [ ] Periodic fever syndromes and autoinflammatory diseases, e.g. PFAPA, FMF, TRAPS, cryopyrinopathies
- [ ] Primary Immune Deficiency syndromes with rheumatic/autoimmune manifestations, e.g. ALPS, CVID, RALD
- [ ] Primary Sjogren's syndrome
- [ ] Sarcoidosis
- [ ] Systemic sclerosis
- [ ] Vasculitis, excluding genetic syndromes (report DADA2, SAVI under genetic vasculopathies)
- [ ] Overlap or undifferentiated rheumatic connective tissue diseases
- [ ] Other

Specify: other primary rheumatic/autoimmune diagnosis

Which subtype of JIA does the patient have?

- ◯ Systemic arthritis
- ◯ Oligoarticular JIA
- ◯ Polyarticular JIA
- ◯ Psoriatic arthritis
- ◯ Enthesitis related arthritis
- ◯ Undifferentiated arthritis
- ◯ Unsure

RF positive (or CCP positive) Polyarticular JIA?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please indicate if the patient has experienced sJIA-associated lung disease:

- ☐ Interstitial lung disease (ILD)
- ☐ Pulmonary alveolar proteinosis (PAP)
- ☐ Pulmonary arterial hypertension (PAH)
- ☐ Other
- ☐ Unsure

Specify other sJIA lung disease

Does the patient have a history of any autoimmune ocular involvement?

- ◯ Yes
- ◯ No
- ◯ Unsure

What is the ocular diagnosis? (Check all that apply)

- ☐ Uveitis
- ☐ Scleritis
- ☐ Retinal vasculitis
- ☐ Other
- ☐ Unsure

Specify uveitis subcategory: (Check all that apply)

- [ ] Anterior
- [ ] Intermediate
- [ ] Posterior
- [ ] Panuveitis
- [ ] Unknown

Specify other ocular disease

_____

Specify autoimmune brain disease type

- ◯ Autoimmune encephalitis (antibody positive, seronegative)
- ◯ Demyelinating disease (NMO, MOG)
- ◯ CNS vasculitis
- ◯ Other
- ◯ Unsure

Specify other autoimmune brain disease type

_____

Secondary rheumatic/autoimmune comorbidities

- ◯ Auto-immune hepatitis
- ◯ Auto-immune thyroid disease
- ◯ Celiac disease
- ◯ Demyelinating disease
- ◯ Diabetes - Type 1
- ◯ Inflammatory bowel disease
- ◯ Macrophage activation syndrome (MAS)
- ◯ Neuromyelitis Optica (NMO)
- ◯ Psoriasis
- ◯ Other rheumatic/autoimmune disease

Specify: other secondary rheumatic/autoimmune diagnosis

_____

Non-autoimmune comorbidities (Check all that apply)

- [ ] None
- [ ] Acquired Immunodeficiency, including HIV
- [ ] Interstitial lung disease (e.g. NSIP, UIP, IPF)
- [ ] Obstructive lung disease (asthma, COPD)
- [ ] Other lung disease
- [ ] Diabetes Type 1
- [ ] Diabetes, Type 2
- [ ] Obesity (BMI >=30)
- [ ] Morbid obesity (BMI >=40)
- [ ] Hypertension
- [ ] Cardiovascular disease, e.g. coronary artery disease, congestive heart failure)
- [ ] Pulmonary hypertension
- [ ] Chronic renal insufficiency or end stage renal disease
- [ ] Cancer
- [ ] Organ transplant recipient
- [ ] Immunodeficiency
- [ ] Inflammatory Bowel Disease, e.g. Crohn's disease, Ulcerative Colitis, Undifferentiated (IBD)
- [ ] Liver disease
- [ ] Chronic neurological or neuromuscular disease
- [ ] Trisomy 21
- [ ] Psychiatric condition (e.g., schizophrenia, bipolar disorder)
- [ ] Pregnancy
- [ ] Post-partum (< 6 weeks)
- [ ] Other
- [ ] Unknown

Specify other comorbidities

Have you also reported this case to the SECURE-IBD COVID-19 Registry (https://covidibd.org)?

- ◯ Yes
- ◯ No
- ◯ Unsure

Rheumatologic/autoimmune disease activity disease activity AT TIME OF COVID-19 SYMPTOM ONSET (or at recognized onset of SARS-CoV-2 infection if asymptomatic):

- ◯ Remission
- ◯ Minimal or low disease activity
- ◯ Moderate disease activity
- ◯ Severe or high disease activity
- ◯ Unknown

Please also indicate the most recent Physician Global Disease Activity Score (PGAS) at or within 90 days before COVID-19 symptom onset, if known:

Range 0 to 10 (0 = no rheumatic/autoimmune disease activity; 10 = most severe activity)

_____

Did the patient experience an exacerbation or other flare of rheumatic/autoimmune disease activity during or after SARS-CoV-2 infection?

- ◯ No rheumatic/autoimmune disease exacerbation
- ◯ Minor rheumatic/autoimmune disease exacerbation
- ◯ Significant rheumatic/autoimmune disease exacerbation
- ◯ Not yet known/Unknown

Glucocorticoids

Was the patient taking glucocorticoids of any type (e.g. prednisone, methylprednisolone) or route of administration (e.g. oral, IV, intra-ocular, intra-articular), within 30 days prior to COVID-19 SYMPTOM ONSET (or prior to SARS-CoV-2 diagnosis if asymptomatic)?

- ◯ Yes
- ◯ No
- ◯ Unknown

What is the dose (prednisone equivalent) of glucorticoid at the time of COVID-19 symptom onset (or at COVID-19 diagnosis if asymptomatic):

_____

Units:

- ◯ mg/day
- ◯ mg/kg/day

Route:

- ◯ Oral
- ◯ Intravenous
- ◯ Ocular
- ◯ Intra-articular
- ◯ Topical

- ◯ Topical
- ◯ Periocular
- ◯ Intraocular

Was this glucocorticoid stopped or continued after COVID-19 symptom onset or after SARS-CoV-2 diagnosis (if asymptomatic)?

- ◯ Stopped
- ◯ Continued
- ◯ Unknown

Was the dosage or frequency of administration changed?

- ◯ Continued unchanged
- ◯ Dosage or frequency changed
- ◯ Unknown

How was this changed?

- ◯ Dose reduced
- ◯ Dose increased
- ◯ Drug interrupted or delayed
- ◯ Unknown
- ◯ Not applicable

Did the patient ever receive rituximab?

- ◯ Yes
- ◯ No
- ◯ Unknown

Immunosuppressive medications

Was the patient on any other immunosuppressive medications within 30 days prior to COVID-19 SYMPTOM ONSET (or prior to SARS-CoV-2 diagnosis if asymptomatic)?

- ◯ None
- ◯ Abatacept
- ◯ Antifibrotics (pirfenidone, nitedinib)
- ◯ Antimalarials (including hydroxychloroquine, chloroquine)
- ◯ Apremilast
- ◯ Azathioprine / 6-MP
- ◯ Belimumab
- ◯ Cyclophosphamide
- ◯ Colchicine
- ◯ Cyclosporine
- ◯ Denosumab
- ◯ IL-1 inhibitors (including anakinra, canakinumab, rilonacept)
- ◯ IL-6 inhibitors (e.g. tocilizumab, sarilumab, siltuximab)
- ◯ IL-12/23 inhibitors (including ustekinemab)
- ◯ IL-17 inhibitors (including secukinumab, ixekizumab)
- ◯ IL-23 inhibitors (including guselkumab)
- ◯ IVIG
- ◯ JAK inhibitors (e.g. tofacitinib, baricitinib, upadacitinib)
- ◯ Leflunomide
- ◯ Methotrexate
- ◯ Mycophenolate mofetil / mycophenolic acid
- ◯ Sulfasalazine
- ◯ Tacrolimus
- ◯ Thalidomide / lenalidomide
- ◯ TNF-inhibitors (including infliximab, etanercept, adalimumab, golimumab, certolizumab, and biosimilars)
- ◯ Steroid eye drops
- ◯ Unknown
- ◯ Other

Was this immunosuppressive medication stopped or continued after COVID-19 symptom onset or after SARS-CoV-2 diagnosis (if asymptomatic)?

- ◯ Stopped
- ◯ Continued
- ◯ Unknown

Was the dosage or frequency of administration changed?

- ◯ Continued unchanged
- ◯ Dosage or frequency changed
- ◯ Unknown

How was this changed?

- ◯ Dose reduced
- ◯ Dose increased
- ◯ Drug interrupted or delayed
- ◯ Unknown
- ◯ Not applicable

At the time of COVID-19 symptom onset (or diagnosis if asymptomatic), was the patient taking any of the following medications?

Nonsteroidal anti-inflammatory (NSAID) | Taking at time of COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Yes
- ◯ No
- ◯ Unsure

Nonsteroidal anti-inflammatory (NSAID) | What was the action taken regarding this medication at or after COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Dose not changed
- ◯ Dose reduced
- ◯ Dose increased
- ◯ Drug interrupted
- ◯ Drug discontinued
- ◯ Unknown

ACE inhibitor | Taking at time of COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Yes
- ◯ No
- ◯ Unsure

ACE inhibitor | What was the action taken regarding this medication at or after COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Dose not changed
- ◯ Dose reduced
- ◯ Dose increased
- ◯ Drug interrupted
- ◯ Drug discontinued
- ◯ Unknown

Angiotensin receptor blocker | Taking at time of COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Yes
- ◯ No
- ◯ Unsure

Angiotensin receptor blocker | What was the action taken regarding this medication at or after COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Dose not changed
- ◯ Dose reduced
- ◯ Dose increased
- ◯ Drug interrupted
- ◯ Drug discontinued
- ◯ Unknown

PD5 inhibitor (e.g., sildenafil) | Taking at time of COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Yes
- ◯ No
- ◯ Unsure

PD5 inhibitor (e.g., sildenafil) | What was the action taken regarding this medication at or after COVID-19 symptom onset (or diagnosis if asymptomatic)?

- ◯ Dose not changed
- ◯ Dose reduced
- ◯ Dose increased
- ◯ Drug interrupted
- ◯ Drug discontinued
- ◯ Unknown

Additional patient demographics

Zip code/Postal code of residence: _____

What was the patient's region of residence around the time of presumed novel coronavirus infection.

Please DO NOT include details on smaller locales and limit your response to broader regions, e.g. county or state level, in order to protect patient privacy. _____

Race/geographic origin

- ☐ Arab
- ☐ Asian
- ☐ Black / African-American
- ☐ Latin American
- ☐ Native American / Aboriginal / 1st Nations
- ☐ Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown or prefer not to answer

Specify Other _____

Ethnicity

- ◯ Hispanic
- ◯ Not Hispanic
- ◯ Unknown or prefer not to answer

Has the patient ever smoked cigarettes, used e-cigarettes, or vaped (including marijuana)?

- ◯ Yes
- ◯ No
- ◯ Unknown

Please indicate

Cigarettes

- ◯ Current
- ◯ Prior only
- ◯ Never
- ◯ Unsure

E-cigarettes or vaping

- ◯ Current
- ◯ Prior only
- ◯ Never
- ◯ Unsure

Insurance type (check all that apply)

- ☐ Private Health Insurance
- ☐ Medicare
- ☐ Medicaid
- ☐ Military Health Care
- ☐ State-specific Plan (not traditional Medicaid)
- ☐ Indian Health Services
- ☐ Non-US Insurance
- ☐ Other
- ☐ None

Insurance type (check all that apply)

- ☐ Public insurance
- ☐ Private insurance
- ☐ Other
- ☐ None

Specify other insurance _____

Laboratory Results

Are there any laboratory test results available related to other infections?

- ◯ Yes
- ◯ No

Pathogen Tests

Influenza A

- ◯ CONFIRMED Positive
- ◯ PROBABLE Positive
- ◯ Negative
- ◯ Results pending
- ◯ Not done
- ◯ Unsure

Influenza B

- ◯ CONFIRMED Positive
- ◯ PROBABLE Positive
- ◯ Negative
- ◯ Results pending
- ◯ Not done
- ◯ Unsure

Other coronavirus (NOT SARS-CoV-2)

- ◯ CONFIRMED Positive
- ◯ PROBABLE Positive
- ◯ Negative
- ◯ Results pending
- ◯ Not done
- ◯ Unsure

RSV

- ◯ CONFIRMED Positive
- ◯ PROBABLE Positive
- ◯ Negative
- ◯ Results pending
- ◯ Not done
- ◯ Unsure

Adenovirus

- ◯ CONFIRMED Positive
- ◯ PROBABLE Positive
- ◯ Negative
- ◯ Results pending
- ◯ Not done
- ◯ Unsure

Other Respiratory Infection (e.g. fungal)

- ◯ CONFIRMED Positive
- ◯ PROBABLE Positive
- ◯ Negative
- ◯ Results pending
- ◯ Not done
- ◯ Unsure

Pathogenic bacteria

- ◯ CONFIRMED Positive
- ◯ PROBABLE Positive
- ◯ Negative
- ◯ Results pending
- ◯ Not done
- ◯ Unsure

Did the patient develop any features concerning for Cytokine Storm Syndrome, including MAS?

- ◯ Yes
- ◯ No
- ◯ Unsure

Cytokine activation labs

WBC (lowest value) | Result

_____

WBC (lowest value) | Units
10^9/L or 10^3/mm^3

Hemoglobin < 9.2 (lowest value) | Result

_____

Hemoglobin < 9.2 (lowest value) | Units

g/dL

Platelets (lowest value) | Result

Platelets (lowest value) | Units
10^9/L or 10^3/mm^3

ESR (lowest value) | Result

ESR (lowest value) | Units
mm/hour

ESR (lowest value) | Upper limit of normal (if applicable)

C-reactive protein (highest value) | Result

C-reactive protein (highest value) | Units

- ◯ mg/dL
- ◯ mg/L

C-reactive protein (highest value) | Upper limit of normal (if applicable)

AST (highest value) | Result

AST (highest value) | Units
U/L

AST (highest value) | Upper limit of normal (if applicable)

ALT (highest value) | Result

ALT (highest value) | Units
U/L

ALT (highest value) | Upper limit of normal (if applicable)

Triglycerides (highest value) | Result

Triglycerides (highest value) | Units
mg/dL

Ferritin (highest value) | Result

Ferritin (highest value) | Units
ng/mL

Fibrinogen (lowest value) | Result

Fibrinogen (lowest value) | Units
mg/dL

Soluble interleukin-2 receptor [sIL-2R] (highest value) | Result

Soluble interleukin-2 receptor [sIL-2R] (highest value) | Units
U/mL

D-dimer | Result

D-dimer | Units

- ◯ ng/mL
- ◯ mg/L

Please indicate any other lab results that were markedly abnormal, as well as any pertinent normal results

Test

- ◯ White blood cell count (WBC)
- ◯ Absolute neutrophil count (ANC)
- ◯ Absolute lymphocyte count (ALC)
- ◯ Hemoglobin
- ◯ Hematocrit
- ◯ Platelet count
- ◯ C-reactive protein (CRP)
- ◯ Erythrocyte sedimentation rate (ESR)
- ◯ Ferritin
- ◯ Creatinine
- ◯ GFR
- ◯ AST (SGOT)
- ◯ ALT (SGPT)
- ◯ Total bilirubin
- ◯ Direct bilirubin
- ◯ D-dimer
- ◯ PT
- ◯ PTT
- ◯ INR
- ◯ C3
- ◯ C4
- ◯ CH50
- ◯ IgG
- ◯ Other laboratory testing

Specify other _____

Result _____

Unit _____

Normal range or value _____

Imaging

Did the patient have any significant imaging findings of COVID-19, including pertinent negatives?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please indicate significant imaging findings, including pertinent negatives

Imaging study

- ◯ CT scan (conventional)
- ◯ High-resolution CT scan
- ◯ CT-PET scan
- ◯ MRI
- ◯ Nuclear scan
- ◯ Plain radiographs (X-rays)
- ◯ Ultrasound
- ◯ Other imaging

Anatomic location

- ☐ Head
- ☐ Neck
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ Other

Result

- ◯ Normal / unremarkable
- ◯ Abnormal
- ◯ Results pending
- ◯ Unknown

Interpretation _____

Based upon the subject's severity level that you have reported, this section can be skipped. Please click 'Next' to proceed.

Additional notes and comments

Do you have any lessons or other aspects from this case to share?

Please DO NOT include any patient names or other direct identifiers.

May we contact you about these additional notes and comments?

- ◯ Yes
- ◯ No

THANK YOU!

THANK YOU!

THANK YOU for your valuable time to complete this survey! We will be providing frequent updates of results received and may contact you in the future for additional reporting as we learn more.

Please accept our sincere wishes that you, your family, your friends, and patients can stay as safe as possible in these challenging times.

Approximately how much time (minutes) did it take you to complete the data collection for this survey?

Now that you are at the end of our survey, do you think this data collection form is:

- ◯ Too long
- ◯ Too short
- ◯ Just about right
- ◯ Other, specify:

Other, specify: